| This repo | ort is required by law (42 USC 1395g; 4 made since the beginning of the cost re | 2 CFR 413.20(b)). Fa | alure to report | can result in | all interim | FORM APPROVED OMB NO. 0938- |) |
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| HOSPITAL | AND HOSPITAL HEALTH CARE COMPLEX COST I | | | CN: 151322 Per | riod: om 01/01/2012 12/31/2012 | Worksheet S Parts I-III | pared: |
| | COST REPORT STATUS | | | | | | |
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| PART II - | - CERTIFICATION | | | | | | |
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The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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| | TAL AND HOSPITAL HEALTH CARE COMPLEX | IDENTIFICATION D | ATA | Prov | ider CCN | : 151322 | Period: From 01/0 To 12/3 | 1/2012 1/2012 | Worksh Part I Date/T 5/30/2 | ime Pro | epared |
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| | Separately Certified ASC Hospital-Based Hospice | | | | | | | | | | 13. |
| | Hospital-Based Health Clinic - RHC | | | | | | | | | | 14. |
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| | n de la companya de | | • | | | | Fro | m • | To | 1. | 19. |
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| .00 | Type of Control (see instructions) Inpatient PPS Information Does this facility qualify for and i disproportionate share hospital adju column 1, enter "Y" for yes or "N" §412.06(c)(2)(Pickle amendment hospi Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in col. Medicaid eligible unpaid days in co out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state eligible unpaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 6. Enter your standard geographic class: Cost reporting period. Enter "1" for | stment, in accordor no. Is this fital?) In column dicaid days on life census days, or is cost reporting in a column dicaid for the life cost reporting in a column dicaid days in column days in column days in column dicaid days in column dicaid days in column days in column days in column days in column dicaid days in column days in column days in column days in column dicaid days in column days | dance with acility su 2, enter " ines 24 an r 3 if dat g period d 2, enter " In-State Medicaid paid days 1.00 | 42 CFR bject t y" for d/or 25 e of di ifferen y" for In-Si Medic eligi unpa day 2.0 | §412.10 o 42 CFR yes or " below? scharge. t from t yes or " cate O caid S ble Me id paid 00 0 | Section N" for no In column Is the he method N" for no ut-of State dicaid id days 3.00 0 | Out-of State Medicaid eligible unpaid 4.00 0 | /2012 9 Medica HMO day | N N N N N N N N N N N N N N N N N N N | ther ficaid days | 23.0 |
| .00 | Type of Control (see instructions) Inpatient PPS Information Does this facility qualify for and i disproportionate share hospital adju column 1, enter "Y" for yes or "N" f §412.06(c)(2)(Pickle amendment hospi which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state eligible unpaid days in col. 4, Medic and eligible but unpaid days in col. Medicaid days in col. 6. Enter your standard geographic class: cost reporting period. Enter "1" for Enter your standard geographic class: cost reporting period. Enter "1" for Enter your standard geographic class: | stment, in according to the state of the sta | dance with acility su 2, enter " ines 24 an r 3 if dat g period d 2, enter " In-State Medicaid paid days 1.00 | 42 CFR bject t y" for d/or 25 e of di ifferen y" for In-Si Medic eligi unpa day 2.0 | §412.10 o 42 CFR yes or " below? scharge. t from t yes or " cate O aid S ble Me id par s 0 0 0 | Section N" for no In column Is the he method N" for no ut-of State dicaid id days 3.00 0 | Out-of State Medicaid eligible unpaid 4.00 0 | /2012 9 Medica HMO day | N N N N N N N N N N N N N N N N N N N | ther ficaid days | 21.0 22.0 23.0 24.0 |
| .00 | Type of Control (see instructions) Inpatient PPS Information Does this facility qualify for and i disproportionate share hospital adju column 1, enter "Y" for yes or "N" f §412.06(c)(2)(Pickle amendment hospi Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state eligible unpaid days in col. 4, Medica and eligible but unpaid days in col. Medicaid days in col. 6. Enter your standard geographic class reporting period. Enter "1" for Enter your standard geographic class reporting period. Enter in column 1. | stment, in accordor no. Is this fital?) In column ital?) In column if census days, on is cost reporting its column its col | dance with acility su 2, enter " ines 24 an r 3 if dat g period d 2, enter " In-State Medicaid paid days 1.00 | 42 CFR bject t y" for d/or 25 e of di ifferen y" for In-Si Meddi eligi unpa day 2.0 | §412.10 o 42 CFR yes or " below? scharge. t from t yes or " cate 0 caid 9 ible Me id par s 0 0 0 0 | Section N" for no In column Is the he method N" for no ut-of State dicaid id days 3.00 0 | Out-of State Medicaid eligible unpaid 4.00 0 | /2012 9 Medica HMO day | N N N N N N N N N N N N N N N N N N N | ther ficaid days | 21 22 23 23 25 26 26 26 |
| 00 | Type of Control (see instructions) Inpatient PPS Information Does this facility qualify for and i disproportionate share hospital adju column 1, enter "Y" for yes or "N" f §412.06(c)(2)(Pickle amendment hospi which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-state eligible unpaid days in col. 4, Medic and eligible but unpaid days in col. Medicaid days in col. 6. Enter your standard geographic class: cost reporting period. Enter "1" for Enter your standard geographic class: cost reporting period. Enter "1" for Enter your standard geographic class: | stment, in accordor no. Is this fital?) In column ital?) In column if census days, on is cost reporting it column ital? In column ital? , enter the language in column ital. t unpaid days in column ital. | dance with acility su 2, enter " ines 24 an r 3 if dat g period d 2, enter " In-State Medicaid paid days 1.00 1.00 | 42 CFR bject t y" for d/or 25 e of di ifferen y" for In-Si Meddi e ligi unpa day 2.0 0 | §412.10 o 42 CFR yes or " below? scharge. t from t yes or " tate O cate O o o o o o o o o o o o o o o o o o o o | Section N" for no In column Is the he method N" for no ut-of State dicaid id days 3.00 0 0 the cost | Out-of State Medicaid eligible unpaid 4.00 0 | /2012 9 Medica HMO day | N N N N N N N N N N N N N N N N N N N | ther ficaid days | 21. 22. 23. 23. 25. 26.4 |

| - Otherwise - co | TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi | ider CCN: 151322 | Period: | | worksh | eet s- | |
|------------------|--|--|--------------------------------------|--------------------|-----------------------------|---------------------------------------|--------------|
| | | | From 01/0 To 12/3 | 01/2012 01/2012 | Part I Date/T 5/30/2 | ime Pr | |
| | | | Begin | | Endi | | |
| | Enter applicable beginning and ending dates of SCH status. Subscript of periods in excess of one and enter subsequent dates. | | 1 | UU | 2. | 00 | 36.0 |
| | if this is a Medicare dependent hospital (MDH), enter the number of point of the cost reporting period | | | 0 | | | 37.0 |
| 36.00 | Enter applicable beginning and ending dates of MDH status. Subscript of periods in excess of one and enter subsequent dates. | line 38 for numb | | | | | 38.0 |
| | | | 1.0 | | Y/ | The second second | |
| 39.00 | Does the facility potentially qualify for the inpatient hospital adjuvolume hospitals as deemed by CMS according to the Federal Register? "Y" for yes or "N" for no. Additionally, does the facility meet the mrequirements in accordance with 42 CFR 412.101(b)(2)? Enter in column "N" for no. | Enter in column | 1 | , | 2.0 | ou. | 39.0 |
| | | | | 1.00 | XVIII | · · · · · · · · · · · · · · · · · · · | |
| 1F 00 | Prospective Payment System (PPS)-Capital | the second property of the second sec | | 1.00 | 2.00 | 3.00 | - |
| | Does this facility qualify and receive Capital payment for disproport with 42 CFR Section §412.320? (see instructions) | | | N | N | N | 45.0 |
| | Is this facility eligible for additional payment exception for extraor pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III. | [and L-1, Parts | I through | N | N | N | 46.0 |
| 10.00 | Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for the facility electing full federal capital payment? Enter "Y" for Teaching Hospitals | yes or "N" for I | 10. | N N | N N | N N | 47.0 48.0 |
| | Is this a hospital involved in training residents in approved GME progor "N" for no. | | | N | | | 56.0 |
| | If line 56 is yes, is this the first cost reporting period during which GME programs trained at this facility? Enter "Y" for yes or "N" for reis "Y" did residents start training in the first month of this cost refor yes or "N" for no in column 2. If column 2 is "Y", complete works "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable to the start of the start o | no in column 1. 1 eporting period? sheet E-4. If col | If column 1 Enter "Y" Umn 2 is | - | | | 57.6 |
| | If line 56 is yes, did this facility elect cost reimbursement for phys defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet Define Costs claimed on line 100 of Worksheet A? If yes, complete Worksheet MS If yes, yes | icians' services | | | | | 58.0 |
| 0.00 | Me you Claiming nursing school and/or allied health costs for a progr | +6 | | N | | | 59.0 |
| | provider-operated criteria under §413.85? Enter "Y" for yes or "N" for | r no. (see instr | uctions) | | | | 60.0 |
| | | Y/N | IME AVE | erage | Direct Avera | | |
| i.oo | Did your facility receive additional FTE slots under ACA section 5503? | 1.00 | 2.0 | 0 | 3.0 | | |
| | Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in colum 2 and direct GME in column 3, from the hospital's three most recent co reports ending and submitted before March 23, 2010. (see instructions ACA Provisions Affecting the Health Resources and Services Administrat Enter the number of FTE residents that your hospital trained in this | mn st | | 0.00 | | 0.00 | 61.0 |
| | cost reporting period for which your hospital received HRSA PCRE fundi | ng 0. | 00 | | | | 62.0 |
| | Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period o HRSA THC program. (see instructions) | f 0. | 00 | | | | 62.0 |
| | Teaching Hospitals that Claim Posidents in Non provides seeding | | | | | | 63.0 |
| .00 | Teaching Hospitals that Claim Residents in Non-Provider Settings Has your facility trained residents in non-provider settings during the Cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) | is N | | | | | |
| .00 | Has your facility trained residents in non-provider settings during the | is N Unweighted | Unweigl | hted R | Ratio (co | o]. 1/ | |
| 3.00 | has your facility trained residents in non-provider settings during the cost reporting period? Enter "Y" for ves or "N" for no in column 1 to | Unweighted FTEs Nonprovider | FTES | in (| Ratio (co (col. 1 2)) | + col. | |
| .00 | has your facility trained residents in non-provider settings during the cost reporting period? Enter "Y" for ves or "N" for no in column 1 to | Unweighted FTES Nonprovider Site | FTES Hospit | in (tal | (col. 1 2)) | + col. | |

| OSPITAL AND HOSPITAL HEALTH CARE COMPI | | | | CCN: 151322 | Period: | | • |
|---|--|--|-------------------|---|-----------------------------------|---|---------|
| | The second of th | | | | From 01/01/2012 To 12/31/2012 | | epared |
| · · · · · · · · · · · · · · · · · · · | Program Name | Program | Code | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | / |
| 5.00 Enter in column 1, if line 63 | 1.00 | 2.0 | 0 | 3.00 | 4.00 | 5.00 | 1 |
| is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in | | | | 0.6 | 0.0 | 0.000000 | 65.0 |
| your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) | | | | | | | |
| | And the second s | | | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 1/ (col. 1 + col. 2)) | and the |
| Section 5504 of the ACA Current > | Ann FTF Beelders | And the second s | | 1.00 | 2.00 | 3.00 | |
| Section 5504 of the ACA Current Y beginning on or after July 1, 201 | ear FIE Kesidents in | Nonprovide | ' setting: | sEffective 1 | or cost report | ing periods | |
| .00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + | curring in all non-p nweighted non-primar l Enter in column 2 | rovider sett y care resid the ratio o tructions) | ings. ent f | 0.0 | 0.00 | 0.000000 | 66.0 |
| | riogram name | | | | | 1 | |
| 7 | | Program | Code | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
| .00 If line 63 is yes, then, for each primary care residency | 1.00 | 2.00 | | FTEs Nonprovider | FTES in Hospital | (col. 3 + col. 4)) 5.00 | |

| Health Financial Systems PERRY COUNTY HOS HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01 | | J of Form (Worksheet Part I Date/Time 5/30/2013 | S-2 Prepare |
|---|--|--|--------|--|-----------------|
| | and the state of t | J., | 1 00 | 2.00 3 | |
| Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or do | | | 1. | 1 2.00 1 3 | |
| Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have a teaching program | ram in the most recent | cost | N | | 70 0 71 |
| report filed on or before November 15, 2004? Enter "Y" for yes this facility train residents in a new teaching program in acco (d)(1)(iii)(0)? Enter "Y" for yes or "N" for no. Column 3: If c respectively in column 3. (see instructions) If this cost repor of the fourth year, enter 4 in column 3, or if the subsequent a program in existence, enter 5. (see instructions) Inpatient Rehabilitation Facility PPS | rdance with 42 CFR §41 olumn 2 is Y, enter 1, ting period covers the cademic years of the n | 2.424 2 or 3 beginning ew teaching | | | |
| 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or subprovider? Enter "Y" for yes and "N" for no. | | | N | 7,000 | 75 |
| 76.00 If line 75 yes: Column 1: Did the facility have a teaching progreporting period ending on or before November 15, 2004? Enter " 2: Did this facility train residents in a new teaching program §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Colum or 3 respectively in column 3. (see instructions) If this cost beginning of the fourth year, enter 4 in column 3, or if the su new teaching program in existence, enter 5. (see instructions) | Y" for yes or "N" for in accordance with 42 in 3: If column 2 is Y, reporting period cover | no. Column CFR enter 1, 2 | | | 0 76 |
| | | | | 1.00 | |
| Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes an | d "N" for no. | | | | 80 |
| TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 86.00 Did this facility establish a new Other subprovider (excluded u §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. | FRA? Enter "Y" for ye nit) under 42 CFR Sect | s or "N" for ion | no. | N | 85 86 |
| | | v 1.00 |) | XIX 2.00 | |
| Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital so yes or "N" for no in the applicable column. | ervices? Enter "Y" for | N | 17 | Υ Υ | 90. |
| 91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applications. | ble column. | N | | N | 91. |
| 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable | certification)? (see | | | N | 92. |
| 93.00 Does this facility operate an ICF\MR facility for purposes of to "Y" for yes or "N" for no in the applicable column. | | N | | N | 93. |
| 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the application. | | N | 0.00 | N | 94. |
| Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column. | "N" for no in the | N | 0.00 | N | 0.00 95. 96. |
| 97.00 If line 96 is "Y", enter the reduction percentage in the application Rural Providers | able column. | | 0.00 | | 0.00 97. |
| 105.00 Does this hospital qualify as a Critical Access Hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-incfor outpatient services? (see instructions) | lusive method of paymer | nt N | İ | | 105. 106. |
| 107.00 Column 1: If this facility qualifies as a CAH, is it eligible of for I &R training programs? Enter "Y" for yes or "N" for no in instructions) If yes, the GME elimination would not be on works 25 and the program would be cost reimbursed. If yes complete wo | column 1. (see neet B, Part I, column rksheet D-2 Part II | N | | N | 107. |
| Column 2: If this facility is a CAH, do I&Rs in an approved med train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for column 2. (see instructions) | yes or "N" for no in | | | | |
| 108.00 Is this a rural hospital qualifying for an exception to the CRN/CFR Section §412.113(c). Enter "Y" for yes or "N" for no. | | _ | | | 108. |
| 1.09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" | thysical Occupational 1.00 2.00 Y | 3.00 Y | | Respirato 4.00 N | ry 109. |
| for yes or "N" for no for each therapy. | | | | | |
| Miscellaneous Cost Reporting Information | | TT NATIONAL AND A SECURE AND A STANDARD STORE AND A STANDARD STORE ASSESSMENT | 1.00 | 2.00 3. | 00 |
| 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" enter the method used (A, B, or E only) in column 2. If column 2 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospital providers) ba 15-1, §2208.1. | is "E", enter in colu long term care (includ sed on the definition | mn 3 | N | | 0 115. |
| 116.00 Is this facility classified as a referral center? Enter "Y" for 17.00 Is this facility legally-required to carry malpractice insurance no. | ? Enter "Y" for yes or | | N N | | 116. 117. |
| 118.00 Is the malpractice insurance a claims-made or occurrence policy? claim-made. Enter 2 if the policy is occurrence. | Enter 1 if the policy | is | 0 | | 118. |

| MOSPITAL AND HOSPITAL HEALTH CARE | E COMPLEX IDENTIFICATION DATA | A Provider | | Period: rom 01/01/2012 | Worksheet S Part I | -2 |
|--|--|---|--|---|----------------------------|-------------------------|
| District Control processes of the August Control of the Control of | | | | To 12/31/2012 | Date/Time P 5/30/2013 9 | repared |
| | | | Premiums | Losses | Insurance | |
| 118.01 List amounts of malpractice | e premiums and paid losses: | | 1.00 | 2.00 | 3.00 | 0110 |
| reprofession of comments and another comments are a second series and the comments and the defendance of the comments and the comments are a comment and the comments are a comments are a comments and the comments are a comments are a comment and the comments are a comments are a comment and the comments are a comment and the | a promoved a second | Color a belief in the color of | | *************************************** | | 0118.0 |
| 118.02 Are malpractice premiums ar Administrative and General and amounts contained there 119.00 DO NOT USE THIS LINE | ? If yes, submit supporting | cost center other schedule listing | than the cost centers | 1.00 N | 2.00 | 118.0 |
| L20.00 Is this a SCH or EACH that \$3121 and applicable amenda "N" for no. Is this a rural Hold Harmless provision in Enter in column 2 "Y" for y | ments? (see instructions) En [.] l hospital with < 100 beds tl ACA §3121 and applicable am ves or "N" for no. | ter in column 1 "Y' hat qualifies for endments? (see ins | " for yes or the Outpatient tructions) | N | N | 119.0 120.0 |
| .21.00 Did this facility incur and Enter "Y" for yes or "N" fo Transplant Center Informat | d report costs for implantab or no. | le devices charged | to patients? | Y | <u> </u> | 121.0 |
| 25.00 Does this facility operate yes, enter certification da | a transplant center? Enter | "Y" for yes and "N | " for no. If | N | | 125.0 |
| L26.00If this is a Medicare certi | ate(s) (mm/dd/yyyy) below. ified kidney transplant cento n date, if applicable, in co | er, enter the cert | ification date | | | 126.0 |
| L27.00 If this is a Medicare certi | ificate, if applicable, in co ified heart transplant center n date, if applicable, in co | r, enter the certif | fication date | | | 127.0 |
| l28.00If this is a Medicare certi | n date, if applicable, in co ified liver transplant center n date, if applicable, in col | r, enter the certif | fication date | | ! | 128.0 |
| 29.00If this is a Medicare certi | ified lung transplant center | enter the certifi | ication date in | | | 129.0 |
| 30.00If this is a Medicare certi | ate, if applicable, in column ified pancreas transplant cen nation date, if applicable, i | nter enter the car | rtification | , | | 130.0 |
| 31.00 If this is a Medicare certi | ified intestinal transplant on nation date, if applicable, i | renter enter the | certification | | | 131.0 |
| 32.00If this is a Medicare certi | ified islet transplant center date, if applicable, in col | r, enter the certif | fication date | | | 132.0 |
| .33.00 If this is a Medicare certi | ified other transplant center Ified other transplant center I date, if applicable, in col | r enter the certif | fication date | | | 133.0 |
| 34.00 If this is an organ procure and termination date, if ap All Providers | ement organization (OPO) ent | ter the OPO number | in column 1 | | : | 134.0 |
| 40.00 Are there any related organ chapter 10? Enter "Y" for y are claimed, enter in colum 1.00 | nization or home office costs /es or "N" for no in column 1 nn 2 the home office chain nu | L. If yes, and home mber. (see instruc | office costs | Y . | Francisco (Constantino) | 140.0 |
| If this facility is part of | f a chain organization, enter nome office contractor name a | and contractor numb | ber. | | of the | |
| 42.00 Street: | Contractor's Nam PO Box: | ie: | Contractor | 's Number: | | 141.0 142.0 |
| 43.00 City: | State: | | Zip Code: | | | 143.0 |
| 44.00 Are provider based physicia | ms' costs included in worksh | NACT A7 | | | 1.00 | |
| 45.00 If costs for renal services services only? Enter "Y" fo | are claimed on Worksheet A | line 74, are they | costs for inpa | itient | Y N | 144.0 |
| enter the approvat date (min | r no in column 1. (See CMS P /dd/vvvv) in column 2 | ub. 15-2, section | 4020) If yes, | 1.00 N | 2.00 | 146.0 |
| 47.00 was there a change in the si 48.00 was there a change in the oi 49.00 was there a change to the si no. | tatistical basis? Enter "Y" rder of allocation? Enter "Y | " for yes or "N" f | or no | N N N | | 147.0 148.0 149.0 |
| College of | | Part A 1.00 | Part B 2.00 | Title V 3.00 | Title XIX 4.00 | |
| 0 Ald- 6131: | a provider that qualifies fo es or "N" for no for each co | r an evemntion fro | - the smaldents | | | . |
| of chargest enter 1 for ye | | | | | N (CT. | 155.0 |
| 55.00 Hospital | manufacture of the second seco | N | N | N | 14 | T22.0 |
| 55.00 Hospital 56.00 Subprovider - IPF | | N N | N | N | N | 156.0 |
| 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER | | N | 1 | | | 156.00 157.00 |
| or charges? Enter "Y" for yes 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY | | N N | N | N | N | ; |

| Health Financial Systems | PERRY (| COUNTY HOSPITAL | | | To Lio | u of Form CMS | 2552 40 |
|--|--|--|--|--|---------------------------------------|------------------------|-------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX | (IDENTIFICATION DATA | A Provider C | CN: 151322 | | | Worksheet S- Part I | 2 epared: |
| Multicampus | The state of the s | The second secon | and he are a first of the second second second | the contract of the contract o | · · · · · · · · · · · · · · · · · · · | 1.00 | - |
| 165.00 Is this hospital part of a Multican Enter "Y" for yes or "N" for no. | mpus hospital that h | as one or more campu | ses in diff | erent CBS | As? | N | 165.00 |
| | Name | County | State Z | ip Code | CBSA | CTF /C | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | FTE/Campus | |
| 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 | - | | 2.00 | 3,00 | 4.00 | 5.00 0.0 | 0166.00 |
| Health Information Technology (HIT) |) incentive in the A | merican Recovery and | Painvastma | int Act | and a | 1.00 | |
| 168.00 If this provider is a CAH (line 105 reasonable cost incurred for the H | under Section §1886 5 is "Y") and is a me T assets (see instru | (n)? Enter "Y" for y eaningful user (line uctions) | es or "N" 167 is "Y" | for no.), enter | | Y 908,81 | 167.00 9168.00 |
| 169.00 If this provider is a meaningful us transition factor. (see instruction | ser (11me 167 is "Y") Ns) | and is not a CAH (| line 105 is | "N"), en | ter the | 0.0 | 0169.00 |

| HOSPIT | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE | STIONNAIRE | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II Date/Time Pre 5/30/2013 9:3 | epared: |
|--------------|---|--|--|----------------|--|--|---------|
| | | | | | 1.00 | 2.00 | 1 |
| | General Instruction: Enter Y for all YES resp mm/dd/yyyy format. | ponses. Enter N for | all NO re | sponses. Ente | r all dates in | the | |
| | COMPLETED BY ALL HOSPITALS | The state of the s | | | | | |
| 1.00 | Provider Organization and Operation Has the provider changed ownership immediate | ly prior to the bea | inning of | the cost | N | 1 | 1.00 |
| | reporting period? If yes, enter the date of | | | | | | 1.00 |
| | | | | Y/N 1.00 | Date 2.00 | 3.00 | |
| .00 | Has the provider terminated participation in yes, enter in column 2 the date of termination voluntary or "I" for involuntary. | | | N | | 3.00 | 2.00 |
| .00 | Is the provider involved in business transaccontracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions) | ., chain home officed to the provider older older of the provider of the control | es, drug r its e board | N | | | 3.0 |
| | entered betrette hat his his his territoria en Materia en en historia en 1 en 12 en 2 en 2 en 200 € en 1. | water a second of the second o | The second second second second second | Y/N | Туре | Date | |
| | Financial Data and Reports | | | 1.00 | 2.00 | 3.00 | |
| 1.00 | Column 1: Were the financial statements pre Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or | Audited, "C" for C | ompiled, | Y | С | 05/01/2013 | 4.00 |
| 5.00 | column 3. (see instructions) If no, see inst. Are the cost report total expenses and total | | from | N | | | 5.00 |
| | those on the filed financial statements? If | yes, submit reconci | liation. | | Y/N | Legal Oper. | |
| | | | | | 1.00 | 2.00 | |
| .00 | Approved Educational Activities Column 1: Are costs claimed for nursing scho | ool? Column 2: Tf | vas is th | ne provider is | | | 6.0 |
| | the legal operator of the program? | | | ic provider 15 | | | |
| 7.00 3.00 | Are costs claimed for Allied Health Programs' Were nursing school and/or allied health programs' | ? If "Y" see instru grams approved and/ | ctions. or renewed | d during the | N N | | 7.00 |
| .00 | cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program | ons. | | | N | | 9.00 |
| | yes, see instructions. | | | • | | 1 | |
| | Was an Intern-Resident program been initiated period? If yes, see instructions. | | | | J N | | 10.00 |
| 1.00 | Are GME cost directly assigned to cost center | rs other than I & R | in an App | proved | N | | 11.00 |
| | Teaching Program on Worksheet A? If yes, see | instructions. | | | j | Y/N | |
| | Bad Debts | ** * * * ****** ** * * * * * * * * * * | | | | 1.00 | |
| 2.00 | Is the provider seeking reimbursement for bad | d debts? If yes, se | e instruct | ions. | | Y | 12.00 |
| 3.00 | If line 12 is yes, did the provider's bad del period? If yes, submit copy. | bt collection polic | y change o | luring this co | st reporting | N | 13.00 |
| | If line 12 is yes, were patient deductibles a | and/or co-payments | waived? Ii | yes, see ins | structions. | N | 14.00 |
| | Bed Complement Did total beds available change from the prior | | | | | 4 7 2 | |
| .3.00 | ord total beds available thange from the price | or cost reporting p | eriou? Ii | | art A | N Part B | 15.00 |
| | | Descriptio 0 | n | Y/N | Date | Y/N | |
| | PS&R Data | 4 | | 1.00 | 2.00 | 3.00 | |
| 6.00 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) | | | Y | 04/02/2013 | Y | 16.00 |
| 7.00 | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns | | | N | | N I | 17.00 |
| 8.00 | 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file | | | N | To a server serv | N | 18.00 |
| 9.00 | this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see | | | N · | · compared to comp | N | 19.00 |
| 0.00 | <pre>instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:</pre> | | | N | | N | 20.00 |

| HOSPIT | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE | STIONNAIRE | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S- Part II | epared: |
|--------|--|---|--|---|--|---|--|
| | | | | F | Part A | Part B | |
| | • | Descrip | tion | Y/N | Date | Y/N | |
| 31 00 | A CONTRACTOR OF THE CONTRACTOR | | | 1.00 | 2.00 | 3.00 | 1 |
| 21.00 | Was the cost report prepared only using the provider's records? If yes, see instructions. | Year or commissioners will support the con- | | N | | N | 21.00 |
| | | | | | | 1 00 | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT | ALS ONLY (EXCEPT | T CHTI DDENS H | OSDTTAL C) | em communication of the contract of the contra | 1.00 | |
| | Capital Related Cost | | | | The first of the second | the make the control of the specific and specific | |
| 22.00 | Have assets been relifed for Medicare purpose | s? If ves. see | instructions | | and the second second second second second | N | 22.00 |
| 23.00 | Have changes occurred in the Medicare depreci reporting period? If yes, see instructions. | ation expense d | ue to apprais | als made dur | ing the cost | N | 22.00 |
| 24.00 | Were new leases and/or amendments to existing | leases entered | into during | this cost re | porting period? | N | 24.00 |
| 25.00 | If yes, see instructions Have there been new capitalized leases entere | d into during t | he cost repor | ting period? | If yes, see | N | 25.00 |
| | Were assets subject to Sec.2314 of DEFRA acqu | | | | | N | 26.00 |
| | instructions. Has the provider's capitalization policy chan | | | | | | |
| | copy. Interest Expense | ged during the t | cost reportin | g perious ii | yes, submit | N | 27.00 |
| 28.00 | were new loans, mortgage agreements or letter | s of credit ente | ered into dur | ing the cost | reporting | · · · · · · · · · · · · · · · · · · · | 28.00 |
| 29.00 | period? If yes, see instructions. Did the provider have a funded depreciation a | ccount and/or bo | ond funds (De | bt Service R | eserve Fund) | N | 29.00 |
| | treated as a funded depreciation account? If Has existing debt been replaced prior to its | Ves. see instru | rtione | | i | N | 30.00 |
| | instructions. Has debt been recalled before scheduled matur | | | | | | |
| | instructions. Purchased Services | | Jance of new | uentr ir yes | , see | N | 31.00 |
| 32.00 | Have changes or new agreements occurred in pa arrangements with suppliers of services? If w | AS SAA instruct | rione | | | N | 32.00 |
| | no, see instructions. | ec. 2135.2 appli | ied pertainin | g to competi | tive bidding? If | N | 33.00 |
| 24.00 | Provider-Based Physicians | | | | | | į |
| | Are services furnished at the provider facili If yes, see instructions. | | | | | Y | 34.00 |
| 35.00 | If line 34 is yes, were there new agreements physicians during the cost reporting period? | or amended exist If ves. see inst | ing agreement | ts with the p | provider-based | N | 35.00 |
| | The state of the s | Complete Company of Company | Market S. Later St. A | make an analysis of the second | Y/N | Date | + |
| | Home Office Costs | Statement of Computation of the | The second secon | | 1.00 | 2.00 | |
| 36.00 | Were home office costs claimed on the cost re | nort? | | | | | |
| 37.00 | If line 36 is yes, has a home office cost star If yes, see instructions. | tement been prep | ared by the H | nome office? | N | | 36.00 37.00 |
| 38.00 | If line 36 is yes , was the fiscal year end or | f the home offic | e different 1 | from that of | N | | 38.00 |
| 9.00 | the provider? If yes, enter in column 2 the f If line 36 is yes, did the provider render se | iscal year end o rvices to other | of the home of chain compone | ffice. ents? If yes, | , N | | 39.00 |
| 0.00 | If line 36 is yes, did the provider render se | | | | N | | 40.00 |
| | instructions. | - | | , | " | | 40.00 |
| | Cost Report Preparer Contact Information | | 1.0 | 0 | 2.0 | 00 | And the state of t |
| 1.00 | Enter the first name, last name and the title. | position RI | ĊН | | FERRIELL | | 41.00 |
| | neid by the cost report preparer in columns 1, respectively. | 2, and 3, | | | | | 71.00 |
| 2.00 | Enter the employer/company name of the cost repreparer. | 1 | LIANT MANAGEM | ENT SERVICES | | | 42.00 |
| | Enter the telephone number and email address o | | | | | | 15 |

| HOSPIT | Financial Systems FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES | PERRY COUNT STIONNAIRE | Provider CCN: 151322 | Period: | u of Form CMS- Worksheet S-2 | |
|--------|--|--|--|---|--|--------|
| | | or Ionnaire | Trovider CCN. 131322 | From 01/01/2012 To 12/31/2012 | Part II Date/Time Pre | pared: |
| | NOTE OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRE | Part B | | | 5/30/2013 9:1 | 3 am |
| | | Date | | | | |
| | | 4.00 | | | | 1 |
| | PS&R Data | war en er | The second secon | NAME OF STREET OF STREET OF STREET | The state of the second state of the second | 1 |
| 16.00 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) | 04/02/2013 | | *************************************** | and the second state of th | 16.0 |
| L7.00 | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) | | | | | 17.0 |
| 18.00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. | | | | | 18.0 |
| 9.00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. | | | | | 19.0 |
| 20.00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: | | | | | 20.0 |
| 21.00 | was the cost report prepared only using the provider's records? If yes, see instructions. | | | | | 21.0 |
| | | | 3.00 | | | |
| 1.00 | Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively. | , 2, and 3, | REIMBURSEMENT MANAGER | | | 41.0 |
| | Enter the employer/company name of the cost r preparer. | | | | | 42.0 |
| 13.00 | Enter the telephone number and email address report preparer in columns 1 and 2, respective | of the cost | | | | 43.0 |

| DSPITAL AND HOSP | TAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provider | | Period: From 01/01/2012 | Worksheet 5-3 | 3 |
|--|--|--|--|-----------------------|----------------------------|--|----------------|
| | | g-mb 1000 A A A A A A A A A A A A A A A A A | more turn to annote to administrating to be about the contract of the contract | | To 12/31/2012 | Part I Date/Time Pre 5/30/2013 9:1 | 13 a |
| | | on a desirable of the second o | arrendos | | | I/P Days / O/P | 2 |
| Compo | nent | Worksheet A Line Number | No. of Beds | Bed Days Available | CAH Hours | Visits / Trips Title V | |
| 00 Hospital Ac 8 exclude S | ults & Peds. (columns 5, 6, 7 and wing Bed, Observation Bed and | 1.00 30.00 | 2.00 | 3.00 7,68 | 4.00 89,424.00 | 5.00 0 |) |
| Hospice day HMO | s) | | | | | | |
| 00 HMO IPF Sub 00 HMO IRF Sub | | | | | | | |
| 00 Hospital Ad | ults & Peds. Swing Bed SNF | | | | | 0 |) |
| 00 Hospital Ad | ults & Peds. Swing Bed NF | | | | | ő | 1 |
| 00 Total Adult beds) (see | s and Peds. (exclude observation instructions) | | 21 | 7,680 | 89,424.00 | 0 |) |
| 00 INTENSIVE C | | 31.00 | 4 | 1,464 | 0.00 | 0 |) |
| O CORONARY CA | | | | 2, 10 | 3.00 | O | 1 |
| .00 BURN INTENS | IVE CARE UNIT TENSIVE CARE UNIT | | - | | | | 1 |
| .00 OTHER SPECI | AL CARE (SPECIFY) | | | | 1 | | 1 |
| .00 NURSERY | | 43.00 | | | | 0 | 1 |
| 00 Total (see | instructions) | | 25 | 9,150 | 89,424.00 | 0 |) 1 |
| .00 SUBPROVIDER | - IPF | | | | | 0 | – |
| .00 SUBPROVIDER | | j | | | | | 1 |
| .00 SUBPROVIDER | SING EACTLITY | | | | | | 1 |
| 00 SKILLED NUR 00 NURSING FAC | ILITY | | | | | | 1 |
| 00 OTHER LONG | TERM CARE | | | | | | 2 2 |
| 00 HOME HEALTH | AGENCY SURGICAL CENTER (D.P.) | 101.00 | | | | 0 | |
| 00 HOSPICE | SURGICAL CENTER (D.P.) | 116.00 | o | (| | | 2 |
| 00 CMHC - CMHC | | 110.00 | U | | 1 | | 2 2 |
| 00 RURAL HEALT | 1 CLINIC | | | | | | 2 |
| 00 Total (sum | JALIFIED HEALTH CENTER | | 3.5 | | | | 2 |
| 00 Observation | Bed Days | | 25 | | : | 0 | 2 |
| .00 Ambulance T | rips | | | | | 0 | 29 |
| .oo employee di .oo employee di | scount days (see instruction) scount days - IRF | 97 | | | | | 30 |
| 00 Labor & del | ivery days (see instructions) | | | | | | 3: |
| 00 LTCH non-co | vered days | I/P Davs | / O/P Visits / | / Trips | Full Time E | nuivalente | 3. |
| Compon | ent | Title XVIII | Title XIX | Total All | Total Interns | Employees On | |
| | - | 6.00 | 7.00 | Patients | & Residents | Payroll | |
| 8 exclude Si | olts & Peds. (columns 5, 6, 7 and ring Bed, Observation Bed and | 2,459 | 382 | 8.00 3,726 | 9.00 | 10.00 | |
| Hospice day: 0 HMO | , | 122 | o | | İ | | |
| 0 HMO IPF Subj | | 0 | o | | | | |
| 0 HMO IRF Subj 0 Hospital Add | rovider Ilts & Peds. Swing Bed SNF | 0 | 0 | _ | | | |
| O Hospital Adı | llts & Peds. Swing Bed NF | 631 | 0 31 | 631 31 | | | |
| O Total Adults | and Peds. (exclude observation | 3,090 | 413 | 4,388 | 1 | | 7 |
| beds) (see : O INTENSIVE CA | nstructions) RF UNIT | 100 | | | | | |
| O CORONARY CAP | E UNIT | 168 | 11 | 248 | | | 8 |
| 00 BURN INTENSI | VE CARE UNIT | | | | | 1 | 10 |
| DU SURGICAL INT | ENSIVE CARE UNIT L CARE (SPECIFY) | | | | | ************************************** | 11 |
| 00 NURSERY | | | 97 | 164 | | | 12 |
| 00 Total (see i | nstructions) | 3,258 | 521 | 4,800 | | 246.74 | 13 14 |
| 00 CAH visits 00 SUBPROVIDER | - TPE | 0 | 0 | 0 | | - 1411 7 | 15 |
| 00 SUBPROVIDER | | | | | | | 16 |
| 00 SUBPROVIDER | Page 1 | | | | | | 17 18 |
| 00 SKILLED NURS 00 NURSING FACI | ING FACILITY | | *************************************** | | | | 19 |
| DO NORSING FACT DO OTHER LONG T | | | | | | | 20 |
| 00 HOME HEALTH | AGENCY | 3,393 | o | 5,947 | 0.00 | 6.64 | 21 22 |
| | URGICAL CENTER (D.P.) | | | 2,217 | 0.00 | ,0.04 | 23 |
| 00 AMBULATORY S | 1 | _, | | | | | |
| 00 ;AMBULATORY S 00 HOSPICE 00 [CMHC - CMHC | WALL TO A STATE OF THE STATE OF | o | 0 | 0 | 0.00 | 0.00 | |
| 00 AMBULATORY S 00 HOSPICE 00 CMHC - CMHC 00 RURAL HEALTH | CLINIC ALIFIED HEALTH CENTER | o | O | 0 | 0.00 | 0.00 | 24 25 26 |

0.00

26.25

27.00

28.00

29.00

30.00

31.00

32.00

33.00

27.00

29.00

Total (sum of lines 14-26)

31.00 Employee discount days - IRF

30.00 Employee discount days (see instruction)

32.00 Labor & delivery days (see instructions)

28.00 Observation Bed Days

Ambulance Trips

33.00 LTCH non-covered days

| HOSPI | TAL WAGE RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | | pared |
|-------|--|--|--|--|-------|
| | | | | Amount Reported 1.00 | 7 |
| | PART IV - WAGE RELATED COSTS | The Property of the Control of the C | the second secon | The second of th | |
| | Part A - Core List | and the second s | | | |
| 1.00 | RETIREMENT COST | | | w | |
| 2.00 | 401K Employer Contributions | | | Ō | |
| 3.00 | Tax Sheltered Annuity (TSA) Employer Contribution | | | . 0 | |
| 1.00 | Nonqualified Defined Benefit Plan Cost (see instructions) | | | 472,622 | 1 |
| 7.00 | Qualified Defined Benefit Plan Cost (see instructions) | | | O | 4. |
| .00 | PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees | The state of the s | | | _ |
| .00 | Legal/Accounting/Management Fees-Pension Plan | | | 0 | |
| .00 | Employee Managed Care Program Administration Fees | | | . 0 | , . |
| | HEALTH AND INSURANCE COST | en en en en en en en en en en en en en e | | 0 | 7. |
| .00 | Health Insurance (Purchased or Self Funded) | | | 2 020 533 | |
| .00 | Prescription Drug Plan | | | 3,030,533 | í |
| 0.00 | Dental, Hearing and Vision Plan | | | 0 | ! |
| 1.00 | Life Insurance (If employee is owner or beneficiary) | | | 27.668 | |
| 2.00 | Accident Insurance (If employee is owner or beneficiary) | | | , | 12 |
| 3.00 | Disability Insurance (If employee is owner or beneficiary) | | | 33.828 | |
| 4.00 | Long-Term Care Insurance (If employee is owner or beneficiary) | 1 | | 05,020 | 1 |
| 5.00 | 'Workers' Compensation Insurance | | | 132.986 | |
| 6.00 | Retirement Health Care Cost (Only current year, not the extra | ordinary accrual require | d by FASB 106. | 0 | |
| | Non cumulative portion) | | - | | |
| 7 00 | TAXES | | | | |
| | FICA-Employers Portion Only | | | 834,366 | |
| | Medicare Taxes - Employers Portion Only | | | 0 | |
| | Unemployment Insurance | | | 12,209 | |
| | State or Federal Unemployment Taxes OTHER | e e e e e e e e e e e e e e e e e e e | | , 0 | 20. |
| 1 00 | | | | | 1 |
| | Executive Deferred Compensation (Other Than Retirement Cost Reinstructions)) | ported on lines I throu | gn 4 above. (see | 0 | 21. |
| 2.00 | Day Care Cost and Allowances | | | ^ | 22 |
| | Tuition Reimbursement | | | 0 | |
| | Total Wage Related cost (Sum of lines 1 -23) | | 1 | 0 4 544 212 | |
| | Part B - Other than Core Related Cost | | | 4,544,212 | 24. |
| 5.00 | OTHER WAGE RELATED COSTS (SPECIFY) | | | Λ | 25. |
| | the state of the s | | | U | : 43. |

| HOME | HEALTH AGENCY STATISTICAL DATA | | | CCN: 151322 | Period: From 01/01/2012 | Worksheet S-4 | |
|--------------|--|---------------------|----------------|--|----------------------------|------------------|---|
| | | | Componen | t CCN: 157177 | To 12/31/2012 | 5/30/2013 9:1 | |
| | | | | | Home Health Agency I | PPS | |
| | | | | | | 00 | |
| 0.00 | County | | | | PERRY 1. | | 0.0 |
| | | Title V | Title XVIII | Title XIX | Other | Total | |
| | HOME HEALTH AGENCY STATISTICAL DATA | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 | Home Health Aide Hours | 0 | (|) | 0 0 | 0 | 1.0 |
| 2.00 | Unduplicated Census Count (see instructions) | 0.00 | 123.00 | All for the contract of the contract of | read a company of | | |
| | | | | MUNDEL OF EM | ployees (Full Ti | me Equivalent) | - Parkey - In the Parkey - In |
| | | Enter the numb | er of hours in | Staff | Contract | Total | |
| | | your norma | l work week | South of the state | | | THE PARTY AND THE PARTY OF THE |
| | | | 0 | 1.00 | 2.00 | 3.00 | |
| 3.00 | HOME HEALTH AGENCY - NUMBER OF EMPLOYEES | I | | | (a) | | |
| 4.00 | Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s) | A. In Application | 0.00 | 0.0 | | |) |
| 5.00 | Other Administrative Personnel | | | 0.0 | 0.00 | 0.00 | 1 |
| 7.00 | Direct Nursing Service Nursing Supervisor | | | 0.0 | 1 | | 1 |
| 3.00 | Physical Therapy Service | | | 0.0 | | | |
| .00 | Physical Therapy Supervisor | | | 0.0 | | | ! |
| 0.00 | Occupational Therapy Service Occupational Therapy Supervisor | | | 0.0 | | | |
| 2.00 | Speech Pathology Service | | | 0.0 | | | 1 |
| 3.00 | Speech Pathology Supervisor | | | 0.0 | | | |
| | Medical Social Service | | | 0.0 | 0.00 | 0.00 | |
| | Medical Social Service Supervisor Home Health Aide | | | 0.0 | | | 1 |
| 17.00 | Home Health Aide Supervisor | | | 0.0 | 1 | | |
| 8.00 | Other (specify) | | | 0.0 | | | |
| 9.00 | HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where | | | á | ai : | | |
| | you provided services during the cost reporting period. | | | | 1 | | 19.0 |
| 20.00 | List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code). | | | 15999 | | | 20.0 |
| | The state of the s | Full Ep | oisodes | | 1 | | |
| | | Without Outliers | With Outliers | | Episodes | Total (cols. | |
| | PPS ACTIVITY DATA | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | ļ |
| | Skilled Nursing Visits | 1,211 | | 1 | 3 5 | 1,269 | 21.0 |
| | Skilled Nursing Visit Charges Physical Therapy Visits | 429,000 | | | 5 1,775 | 449,570 | 22.0 |
| 4.00 | Physical Therapy Visit Charges | 1,098 282,915 | | | 6 1,032 | 1,108 285,753 | |
| 5.00 | Occupational Therapy Visits | 578 | 0 | , | 1 2 | 581 | |
| 7.00 | Occupational Therapy Visit Charges Speech Pathology Visits | 129,993 | | | _1 1 | 130,668 | 26.0 |
| 8.00 | Speech Pathology Visit Charges | 48 12,384 | | | 0 0 | 48 12,384 | |
| 9.00 | Medical Social Service Visits | 21 | 0 | | 2 0 | 23 | i |
| 0.00 1.00 | Medical Social Service Visit Charges Home Health Aide Visits | 6,174 | | | | 6,762 | 30.0 |
| 2.00 | Home Health Aide Visit Charges | 364 67,804 | 0 | | 0 0 | 364 67,804 | |
| 3.00 | Total visits (sum of lines 21, 23, 25, 27, | 3,320 | Ö | | 1 | 3,393 | |
| 4.00 | 29, and 31) Other Charges | | _ | | | | |
| 5.00 | Total Charges (sum of lines 22, 24, 26, 28, | 928,270 | 0 0 | 21,41 | 0 0 4 3,257 | 952,941 | |
| | 30, 32, and 34) Total Number of Episodes (standard/non | 153 | | 21,41 | | | 36.0 |
| 0.00 | | 1 | | | , – | _, 0 | 23.00 |
| | outlier) Total Number of Outlier Episodes | | o | | o | | 37.0 |

| HOSPITAL | UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151322 | Period: | Worksheet 5-10 | 0 |
|---------------------------------------|--|--|--|------------------------|------------|
| | | | From 01/01/2012 To 12/31/2012 | Date/Time Pre | pared |
| | American distribution of the contract of the c | AND THE RESIDENCE OF A STATE OF THE STATE OF | | 5/30/2013 9:1 | 3 am |
| energe and a second representation of | | Martin of the control | | 1.00 | |
| | compensated and indigent care cost computation | 4.11. 34.1. 366 | | | |
| | st to charge ratio (Worksheet C, Part I line 202 column 3 divi licaid (see instructions for each line) | ded by line 202 colu | מ חוו | 0.369412 | 1.0 |
| | revenue from Medicaid | The second secon | | 1 007 503 | 2. |
| | you receive DSH or supplemental payments from Medicaid? | | | 1,987,593 | 2.0 3.0 |
| .00 If | line 3 is "yes", does line 2 include all DSH or supplemental | navments from Medica | 142 | Y N | 4. |
| .00 If | line 4 is "no", then enter DSH or supplemental payments from | payments from meurca Medicaid | iu: | Ν 0 | |
| .00 Med | dicaid charges | medicald | | 10.069.340 | |
| | dicaid cost (line 1 times line 6) | | | 3,719,735 | |
| | fference between net revenue and costs for Medicaid program () | ine 7 minus sum of 1 | inac 2 and 5. if | 1,732,142 | 1 |
| < 7 | zero then enter zero) | THE THIRTIUS SUM OF T | ines 2 and 3, 11 | 1,732,142 | 0. |
| | te Children's Health Insurance Program (SCHIP) (see instructi | ons for each line) | | | |
| .00 Net | t revenue from stand-alone SCHIP | ono tor cach time, | | o | 9. |
| | and-alone SCHIP charges | | | Ö | 1 |
| | and-alone SCHIP cost (line 1 times line 10) | | | Ö | |
| 2.00 Dil | fference between net revenue and costs for stand-alone SCHIP (| line 11 minus line 9 | if < zero then | Ö | ! |
| . ent | ter zero) | == | , ,, , , , , , , , , , , , , , , , , , , | Ü | |
| Oth | er state or local government indigent care program (see instr | uctions for each lin | e) | | |
| 3.00 Net | t revenue from state or local indigent care program (Not inclu | ded on lines 2, 5 or | 9) | 0 | 13. |
| 4.00 Cha | arges for patients covered under state or local indigent care | program (Not include | d in lines 6 or | Ö | |
| 10) | | | | · | |
| 5.00 Sta | ate or local indigent care program cost (line 1 times line 14) | | | 0 | 15. |
| 6.00 Di1 | fference between net revenue and costs for state or local indi | gent care program (1 | ine 15 minus line | 0 | 16. |
| | if < zero then enter zero) | | | | |
| Unc | ompensated care (see instructions for each line) | | | | |
| /.00 Pri | vate grants, donations, or endowment income restricted to fun | ding charity care | | 0 | |
| 8.00 Gov | ernment grants, appropriations or transfers for support of ho | spital operations | | 0 | 18. |
| 9.00 Tot 8. | tal unreimbursed cost for Medicaid , SCHIP and state and local 12 and 16) | indigent care progr | ams (sum of lines | 1,732,142 | 19. |
| | Total Control of the | Uninsured | Insured | Total (col. 1 | |
| | | patients | patients | + col. 2) | |
| | A CONTRACT OF THE PROPERTY OF | 1.00 | 2.00 | 3.00 | |
| 0.00 Tot | cal initial obligation of patients approved for charity care (| at full 2,143, | 877 0 | 2,143,877 | 20. |
| cha | arges excluding non-reimbursable cost centers) for the entire | facility | | | |
| 1.00 Cos | st of initial obligation of patients approved for charity care | (line 1 791, | 974 0 | 791,974 | 21. |
| | nes line 20) | | | | |
| 2.00 Par | rtial payment by patients approved for charity care | | 0 0 | _ | 22. |
| 3.00 COS | et of charity care (line 21 minus line 22) | 791, | 974 0 | 791,974 | 23. |
| | | | | The second second | |
| . 00 nos | or the amount in Time 20 and and 2 days and a few and a | | | 1.00 | |
| 1.00 DUE | s the amount in line 20 column 2 include charges for patient posed on patients covered by Medicaid or other indigent care p | days beyond a length | of stay limit | | 24. |
| INIA SUU TE | line 24 is "yes," charges for patient days beyond an indigen | rogram? | | _ | |
| 6.00 Tot | al bad debt expense for the entire hospital complex (see inst | t care program's len | or stay limit | | 25. |
| 7.00 Med | licare bad debts for the entire hospital complex (see instruct | ruccions) | | 5,312,005 | |
| R.OO Non | n-Medicare and Non-Reimbursable bad debt expense (line 26 minu | 1005) a lána 27) | | 442,917 | |
| 9.00 Cos | it of non-Medicare bad debt expense (line 1 times line 28) | 5 (file 2/) | | 4,869,088 | |
| 0.00 Cos | it of non-Medicare uncompensated care (line 23 column 3 plus 1 | ino 201 | | 1,798,700 | |
| 1.00 Tot | cal unreimbursed and uncompensated care cost (line 19 plus lin | 1116 (3) | | 2,590,674 4,322,816 | |
| | | | | | |

| ECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE | OF EXPENSES | Provider | F | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | |
|--|--|--|--|---|--|------------|
| The second secon | | F | *************************************** | | 5/30/2013 9:1 | |
| Cost Center Description | Salaries | Other | Total (col. 1 + col. 2) | Reclassificati ons (See A-6) | Trial Balance (col. 3 +- | |
| estandique y encountry approximate in a summa quantum production of the standard control of the standa | 1.00 | 2.00 | 3.00 | 4.00 | col. 4) 5.00 | - 100 |
| GENERAL SERVICE COST CENTERS .00 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | 1 | The second secon | |
| .00 00200 NEW CAP REL COSTS-BLDG & FIXT | | 1,062,349 | 1,062,349 | | 1,345,671 | |
| .00 00400 EMPLOYEE BENEFITS | 126,528 | 4,291,342 | | | 94,691 36,496 | |
| .00 00500 ADMINISTRATIVE & GENERAL | 1,810,118 | , , | , | | 6,184,995 | 1 |
| .00 00700 OPERATION OF PLANT | 294,921 | | | | 1,478,214 | |
| .00 00800 LAUNDRY & LINEN SERVICE | 908 | | | | 95,504 | |
| .00 00900 HOUSEKEEPING 0.00 01000 DIETARY | 207,245 | | 1 | | 425,545 | |
| 1.00 01100 CAFETERIA | 253,411 | 193,994 | 447,405 | 1 1 | 499,570 | 1 |
| 3.00 01300 NURSING ADMINISTRATION | 553,748 | 9,538 | _ | | 140,206 676,186 | |
| 6.00 01600 MEDICAL RECORDS & LIBRARY | 176,080 | 1 | | | 449,109 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | p= | | | | |
| 0.00 03000 ADULTS & PEDIATRICS 1.00 03100 INTENSIVE CARE UNIT | 1,555,228 | | | | 2,567,418 | |
| 3.00 04300 NURSERY | 271,198 27,658 | | | 1 ' 1 | 314,108 | |
| ANCILLARY SERVICE COST CENTERS | 27,038 | 0 | 27,658 | 29 | 27,687 | 43 |
| 0.00 05000 OPERATING ROOM | 448,693 | 549,930 | 998,623 | 116,619 | 1,115,242 | 50 |
| 2.00 05200 DELIVERY ROOM & LABOR ROOM | 27,307 | 0 | 27,307 | | 27,335 | |
| 4.00 05400 RADIOLOGY-DIAGNOSTIC 0.00 06000 LABORATORY | 861,744 | | 1,835,736 | i i | 2,167,577 | 54 |
| 2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 627,194 10,005 | | 1,378,404 | | 1,502,469 | 1 |
| 5.00 06500 RESPIRATORY THERAPY | 476,819 | | 162,512 754,824 | | 162,524 | |
| 5.00 06600 PHYSICAL THERAPY | 21,380 | 395,402 | 416,782 | | 1,101,902 419,884 | |
| 7.00 06700 OCCUPATIONAL THERAPY | 0 | 116,115 | 116,115 | | 116,092 | 1 |
| 3.00 06800 SPEECH PATHOLOGY | 0 | 148,151 | 148,151 | | 148,151 | |
| 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 45,916 | 421,924 | 467,840 | 1 | 485,067 | 71 |
| .00 07300 DRUGS CHARGED TO PATIENTS | 82 650 | 2 280 070 | 2 272 620 | 35,.00 | 59,768 | |
| OUTPATIENT SERVICE COST CENTERS | 82,659 | 2,289,979 | 2,372,638 | 21,599 | 2,394,237 | 73 |
| .00 09000 CLINIC | 205,846 | 51,856 | 257,702 | 65,100 | 322,802 | 90 |
| .00 09100 EMERGENCY | 814,578 | 1,593,129 | 2,407,707 | | 2,635,194 | |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | ,, | , | _,0_0,00, | 92 |
| OTHER REIMBURSABLE COST CENTERS 5.00 09500 AMBULANCE SERVICES | T | | | | | |
| 1.00 10100 HOME HEALTH AGENCY | 511,259 293,494 | 358,594 329,611 | 869,853 | | 1,008,114 | } |
| SPECIAL PURPOSE COST CENTERS | 233,434 | 325,011 | 623,105 | 157,747 | 780,852 | TOT |
| 3.00 11300 INTEREST EXPENSE | | 77,568 | 77,568 | -77,568 | 0 | 113 |
| 6.00 11600 HOSPICE 8.00 SUBTOTALS (SUM OF LINES 1-117) | 0 | 8 | 8 | 0 | | 116 |
| 8.00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS | 9,703,937 | 19,460,963 | 29,164,900 | -382,282 | 28,782,618 | 118 |
| 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | n. | | | 7.00 |
| 2.00 19200 PHYSICIANS' PRIVATE OFFICES | 2,509,621 | 1,797,228 | 4,306,849 | 406,933 | 4,713,782 | 190 |
| 2.01 19201 MARKETING | 35,118 | 228,119 | 263,237 | | 238,586 | |
| 00.00 TOTAL (SUM OF LINES 118-199) | 12,248,676 | 21,486,310 | 33,734,986 | | 33,734,986 | |
| Cost Center Description | Adjustments (See A-8) 6.00 | Net Expenses For Allocation 7.00 | | | , | |
| GENERAL SERVICE COST CENTERS | the state of the s | | e decembration of the second o | | | |
| 00 00100 NEW CAP REL COSTS-BLDG & FIXT | -155,533 | 1,190,138 | | | | 1 |
| 00 00200 NEW CAP REL COSTS-MVBLE EQUIP | -1,439 | 93,252 | | | | 2 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL | 120 505 | 36,496 | | | | 4 |
| 00 00700 OPERATION OF PLANT | -129,505 -22,764 | 6,055,490 1,455,450 | | | *************************************** | 5. |
| 00 00800 LAUNDRY & LINEN SERVICE | -22,764 | 95,504 | | | | 8 |
| 00 00900 HOUSEKEEPING | ō | 425,545 | | | 1 | 9 |
| .00 01000 DIETARY | -41 | 499,529 | | | and the state of t | 10 |
| .00 01100 CAFETERIA .00 01300 NURSING ADMINISTRATION | -50,188 | 90,018 | | | | 11 |
| 00 01600 MEDICAL RECORDS & LIBRARY | -3,748 | 676,186 | | | | 13 |
| INPATIENT ROUTINE SERVICE COST CENTERS | -5,740 | 445,361 | manufacture and a community of the commu | | | 16 |
| 00 03000 ADULTS & PEDIATRICS | 0 | 2,567,418 | | | | 30 |
| 00 03100 INTENSIVE CARE UNIT | 0 | 314,108 | | | | 31 |
| 00 04300 NURSERY | 0 | 27,687 | | 7 y 10 mm | | 43. |
| ANCILLARY SERVICE COST CENTERS .00 05000 OPERATING ROOM | 303 405 | | T S TORONOUS SAME A SAME A SAME A SAME A SAME A SAME A SAME A SAME A SAME A SAME A SAME A SAME A SAME A SAME A | | | |
| 00 05200 DELIVERY ROOM & LABOR ROOM | -282,480 | 832,762 | | | | 50 |
| .00 05400 RADIOLOGY-DIAGNOSTIC | -99,341 | 27,335 2,068,236 | | | | 52. |
| .00 06000 LABORATORY | -99, 341 | 1,502,469 | | | į | 54. |
| .00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | Ö | 162,524 | | | | 60. 62. |
| .00 06500 RESPIRATORY THERAPY | -191,264 | 910,638 | | | | 65. |
| .00 06600 PHYSICAL THERAPY | 0 | 419,884 | | | | 66. |

| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE | PERRY COUNT OF EXPENSES | Provider CCN: 1513 | 22 Period: | u of Form CMS-2552-1 Worksheet A |
|---|----------------------------|--------------------------------|--|---------------------------------------|
| | | | From 01/01/2012 To 12/31/2012 | Date/Time Prepared: 5/30/2013 9:13 am |
| Cost Center Description | Adjustments (See A-8) | Net Expenses For Allocation | The state of the s | |
| | 6.00 | 7.00 | | |
| 67.00 06700 OCCUPATIONAL THERAPY | 0 | 116,092 | | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 148,151 | | 68.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | -86,229 | | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 59,768 | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | -1,568 | | | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | whomas of the Table | | THE STATE OF THE S | |
| 90.00 09000 CLINIC | 0 | 322,802 | war war and the second of the | 90.00 |
| 91.00 09100 EMERGENCY | -1,217,175 | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 1,720,025 | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | I | L | | 92.00 |
| 95.00 09500 AMBULANCE SERVICES | -4.074 | 1,004,040 | | 95.00 |
| 101.00 10100 HOME HEALTH AGENCY | -2,574 | | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | -,,,, | ,,,,,,,, | | 101.00 |
| 113.00 11300 INTEREST EXPENSE | 0 | 0 | | 113.00 |
| 116.00 11600 HOSPICE | -8 | 0 | | 116.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) | -2,247,931 | 26,534,687 | | 4 |
| NONREIMBURSABLE COST CENTERS | | 20,337,007 | · | 118.00 |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | 100.00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 4,713,782 | | 190.00 |
| 192.01 19201 MARKETING | 0 | | | 192.00 |
| 200.00 TOTAL (SUM OF LINES 118-199) | 2 247 021 | 238,586 | | 192.01 |
| | -2,247,931 | 31,487,055 | | 200.00 |

| | h Financial Systems SSIFICATIONS | The Control of the Co | PERRY COUNTY | | CCN: 151322 | Period: | J of Form CM Worksheet A | |
|------------|---|--|--|-------------------------|--|--|--|--|
| | | | | 1,001001 | CCH. 131322 | From 01/01/2012 To 12/31/2012 | Date/Time P | repared: |
| | | Increases | to a defend where the same is a second of the same same and | | manufacture of the substitution of the substit | | 5/30/2013 9 | :13 am |
| | Cost Center | Line # | Salary | Other | | | | C-C-C-C-C-C-C-C-C-C-C-C-C-C-C-C-C-C-C- |
| | 2.00 | 3.00 | 4.00 | 5.00 | | | | |
| 1.00 | A - CAFETRIA COST | | and an income and a second second second second second second second second second second second second second | | provide at a constraint of the | Action Committee | | |
| 1.00 | CAFETERIATOTALS | 11.00 | 79,517 | 60,872 | | | | 1.0 |
| | B - INTEREST EXPENSE | | 79,517 | 60,872 | | | - contract of the contract of | |
| 1.00 | NEW CAP REL COSTS-MVBLE | 2.00 | 0 | 0F C11 | MANAGEMENT OF THE CONTRACTOR O | magnification of the extremely the first transfer age. | | |
| | EQUIP | 2.00 | U | 85,611 | | | | 1.0 |
| 2.00 | | 0.00 | О | 0 | | | | 2.0 |
| | TOTALS | | ō | 85,611 | | | | 2.0 |
| | C - LEASE EXPENSE | The second secon | and the communication of the authorization | | ************************************** | The first december opening with the second control of the second c | - recommend to the second second | |
| 1.00 | NEW CAP REL COSTS-BLDG & | 1.00 | 0 | 131,883 | | | | 1.0 |
| .00 | FIXT | | | | | | | |
| 3.00 | | 0.00 | 0 | 0 | | | | 2.0 |
| 1.00 | | 0.00 | 0 | 0 | | | | 3.0 |
| .00 | | 0.00 0.00 | 0 | 0 | | | | 4.0 |
| 5.00 | | 0.00 | -1 | 0 | | | | 5.0 |
| .00 | , | 0.00 | 0 | 0 | | | | 6.0 |
| .00 | | 0.00 | o | 0 | | | | 7.0 |
| .00 | * | 0.00 | o | 0 | | | | 8.0 |
| 0.00 | | 0.00 | ŏ | n | | | | 9.0 |
| 1.00 | | 0.00 | o | Ö | | | | 11.0 |
| | TOTALS | | 0 | 131,883 | | | | 11.0 |
| .00 | D - INSURANCE EXPENSE | 1 | | | | *** | the state of the second of the | |
| .00 | NEW CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 15,123 | | | | 1.0 |
| .00 | NEW CAP REL COSTS-MVBLE | 2 00 | | | | | | |
| | EQUIP | 2.00 | 0 | 14,471 | | | | 2.0 |
| | TOTALS | | Ö | 29,594 | | | | |
| | F - GAIN/LOSS FIXED ASSETS | | O _I , | 29,394 | | | | |
| .00 | ADMINISTRATIVE & GENERAL | 5.00 | o | 5,391 | | | | |
| | TOTALS | | Ŏ | 5,391 | | | | 1.0 |
| | G - DRUGS CHARGED | , | • 1 | 3,331 | | | | |
| .00 | DRUGS CHARGED TO PATIENTS | 73.00 | 0 | 70,477 | | | | 1.0 |
| .00 | | 0.00 | 0 | 0 | | | | 2.0 |
| .00 | | 0.00 | 0 | 0 | | | | 3.0 |
| .00 .00 | | 0.00 | 0 | 0 | | | | 4.0 |
| .00 | TOTALS | 0.00 | 0 | 0 | | | | 5.00 |
| | J - BILLABLE SUPPLIES | | 0 | 70,477 | | | | |
| .00 | MEDICAL SUPPLIES CHARGED TO | 71.00 | 0 | CC 040 | | | | |
| | PATIENTS | 71.00 | 0 | 66,910 | | • | | 1.0 |
| .00 | IMPL. DEV. CHARGED TO | 72.00 | 0 | 10,046 | | | | |
| | PATIENT | | • | 10,040 | | | | 2.0 |
| .00 | | 0.00 | o | 0 | | | | 3.00 |
| .00 | | 0.00 | 0 | 0 | | | | 4.00 |
| .00 | | 0.00 | 0 | 0 | | | | 5.00 |
| .00 .00 | ** | 0.00 | 0 | 0 | | | | 6.00 |
| .00 | : | 0.00 | 0 | 0 | | | | 7.0 |
| .00 | WYCOCA | 0.00 | 0 | 0 | | | | 8.0 |
| 00.0 | | 0.00 | 0 0 | 0 | | | | 9.0 |
| .00 | 1 | 0.00 | 0 | 0 | | | | 10.00 |
| .00 | | 0.00 | o | 0 | | | | 11.00 |
| .00 | g | 0.00 | Ŏ | 0 | | | | 12.0 |
| | TOTALS | | o | 76,956 | | | | 13.00 |
| | K - PLANT COST | | and the second s | | | Commence of the commence of th | TANK I W. C. | |
| 00 | OPERATION OF PLANT | 7.00 | 0 | 84,442 | | | | 1.00 |
| 00 | | 0.00 | 0 | 0 | | | | 2.00 |
| | TOTALS | | 0 | 84,442 | | | | 2.00 |
| 00 | M - YELLOW PAGES ADMINISTRATIVE & GENERAL | | | أأسته المستريق المستدار | | | | 900 |
| ~~ | TOTALS | 5.00 | 0 | 32,263 | | | * ***** ** ** | 1.00 |
| | P - IMPLANTABLE DEVICE | | 0 | 32,263 | water a second of the second o | | | |
| 00 | IMPL. DEV. CHARGED TO | 72 00 | · | 40 =05 | | | - | |
| | PATIENT | 72.00 | 0 | 49,722 | | | | 1.00 |
| | TOTALS | | ō | 49,722 | | | | |
| | R - PAYROLL | · · · · · · · · · · · · · · · · · · · | , VI | 79,744 | | to the second second | | |
| 00 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 666,893 | The state of the state of | | | |
| 00 | OPERATION OF PLANT | 7.00 | Ŏ | 162,360 | | | | 1.00 |
| 00 | LAUNDRY & LINEN SERVICE | 8.00 | o | 4 | | | | 2.00 |
| 90 | HOUSEKEEPING | 9.00 | 0 | 166,093 | | | | 3.00 4.00 |
| 00 | Dietary Cafeteria | 10.00 | 0 | 192,554 | | | | 5.00 |
| ባለ . | LAPE LEKIA | 11.00 | o i | | | | | |
| | NURSING ADMINISTRATION | 13.00 | 0 | 352 112,900 | | | | 6.00 |

| | Financial Systems | | PERRY COUNTY | HOSPITAL | | In Lieu of Form CMS-2552- | | | |
|--------|--|---|--------------|-----------|-------------|----------------------------|----------------------------|-------|--|
| RECLAS | SIFICATIONS | | | Provider | CCN: 151322 | Period: From 01/01/2012 | Worksheet A | -6 | |
| | Special for any entropy and the control of the cont | The American are Article property and the second con- | | | | To 12/31/2012 | Date/Time P 5/30/2013 9 | | |
| | The state of the s | Increases | | | | | | 1 | |
| | Cost Center | Line # | Salary | Other | | | | | |
| | 2.00 | 3.00 | 4.00 | 5.00 | | | | | |
| 8.00 | MEDICAL RECORDS & LIBRARY | 16.00 | 0 | 110,932 | | | | 8.0 | |
| 9.00 | ADULTS & PEDIATRICS | 30.00 | o | 591,288 | | | | 9.0 | |
| 10.00 | INTENSIVE CARE UNIT | 31.00 | 0 | 30,564 | | | | 10.0 | |
| 11.00 | NURSERY | 43.00 | 0 | 29 | | | | 11.0 | |
| 12.00 | OPERATING ROOM | 50.00 | 0 | 170,560 | | | | 12.0 | |
| 13.00 | DELIVERY ROOM & LABOR ROOM | 52.00 | Ō | 28 | | | | 13.0 | |
| 14.00 | RADIOLOGY-DIAGNOSTIC | 54.00 | ō | 333,165 | | | | 14.0 | |
| 15.00 | LABORATORY | 60.00 | n | 124,065 | | | | 15.0 | |
| L6.00 | WHOLE BLOOD & PACKED RED BLOOD CELLS | 62.00 | o | 12 1,003 | | | | 16.0 | |
| L7.00 | RESPIRATORY THERAPY | 65.00 | o | 364,731 | | | | 17.0 | |
| | PHYSICAL THERAPY | 66.00 | o | 3,754 | | | | | |
| | MEDICAL SUPPLIES CHARGED TO PATIENTS | 71.00 | ŏ | 39 | | | | 18.0 | |
| 20.00 | DRUGS CHARGED TO PATIENTS | 77.00 | | | | | | | |
| | CLINIC | 73.00 | U | 14,763 | | | | 20. | |
| | EMERGENCY | 90.00 | 0 | 65,253 | | | | 21. | |
| | ; — · · — · · — · · — · · | 91.00 | 0 | 242,559 | | | | 22. | |
| | AMBULANCE SERVICES | 95.00 | 0 | 158,005 | | | | 23.6 | |
| | HOME HEALTH AGENCY | 101.00 | 0 | 164,570 | | | | 24.0 | |
| | PHYSICIANS' PRIVATE OFFICES | 192.00 | 0 | 698,289 | | | | 25.0 | |
| | MARKETING | 192.01 | 0 | 7,612 | | | | 26. | |
| | TOTALS | | 0 | 4,381,374 | | | | | |
| | S - DEPRECIATION | | | | | | | | |
| | NEW CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 136,316 | | | | 1. | |
| | TOTALS | | o | 136.316 | | | | | |
| 500.00 | Grand Total: Increases | | 79.517 | 5,144,901 | | | | 500.0 | |

| | SSIFICATIONS | | | Provider | | Period: From 01/01/2012 | Worksheet | MS-2552-1 A-6 |
|--------------|--|--|--|--|---------------|--|---------------------------------------|----------------------|
| | The state of the s | enterna (1960). E. A. Andrijongijski odno postana (1971). K. S. S. S. Sanska | and the constraint the constraint of the | 1. 11 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1 | | To 12/31/2012 | Date/Time 5/30/2013 | Prepared: 9:13 am |
| | Cost Center | Decreases | | | | | 2 (7) | |
| | Cost Center 6.00 | Line # 7.00 | Salary 8.00 | Other 9.00 | Wkst. A-7 Ref | • | | |
| | A - CAFETRIA COST | Andrew Communication | 0.00 | 9.00 | 10.00 | | The Article Spinish Spinish Co., 1997 | |
| 1.00 | DIETARY | 10.00 | 79,517 | 60,872 | | V | NAME OF TAXABLE PROPERTY. | |
| | TOTALS | | 79,517 | 60,872 | | <u>y</u> | | 1.00 |
| | B - INTEREST EXPENSE | | | 00,012 | | 1 , | | - |
| 1.00 | INTEREST EXPENSE | 113.00 | 0 | 77,568 | 10 |) | | 1.00 |
| 2.00 | PHYSICIANS' PRIVATE OFFICES | 192.00 | 0 | 8,043 | -(| | | 2.00 |
| | TOTALS | | 0 | 85,611 | : | | | 2.00 |
| | C - LEASE EXPENSE | | | | | | | İ |
| 1.00 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 4,327 | Ġ | | | 1.00 |
| 2.00 3.00 | OPERATION OF PLANT | 7.00 | 0 | 553 | (| | | 2.0 |
| 1.00 | MEDICAL RECORDS & LIBRARY ADULTS & PEDIATRICS | 16.00 | 0 | 24,619 | (| | | 3.0 |
| 5.00 | OPERATING ROOM | 30.00 50.00 | 0 | 15,226 | Ç | 1 | | 4.0 |
| 5.00 | RADIOLOGY-DIAGNOSTIC | 54.00 | 0 | 23 | (| | | 5.0 |
| 7.00 | RESPIRATORY THERAPY | 65.00 | 0 | 1,268 17,607 | (| | | 6.00 |
| 3.00 | PHYSICAL THERAPY | 66.00 | 0 | 365 | (| | | 7.00 |
| 9.00 | DRUGS CHARGED TO PATIENTS | 73.00 | ŏ | 63,633 | (| 1 | | 8.00 |
| LO.00 | EMERGENCY | 91.00 | ŏ | 501 | (| j . | | 9.00 |
| 1.00 | PHYSICIANS' PRIVATE OFFICES | 192.00 | o | 3,761 | (| 1 | | 10.00 |
| | TOTALS | | 0 | 131,883 | | 1 | | 11.00 |
| | D - INSURANCE EXPENSE | ************************************** | | / | *** | | | 4 |
| .00 | AMBULANCE SERVICES | 95.00 | 0 | 15,123 | g |) | | 1.00 |
| .00 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 14,471 | 10 | | | 2.00 |
| | TOTALS | | 0 | 29,594 | | | | |
| .00 | F - GAIN/LOSS FIXED ASSETS | 2002 | 1 | | | | | |
| 00 | NEW CAP REL COSTS-MVBLE EQUIP | 2.00 | 0 | 5,391 | 10 | | | 1.00 |
| | TOTALS | | | = ===== | | | | |
| | G - DRUGS CHARGED | | 0 | 5,391 | | la de la companya de la companya de la companya de la companya de la companya de la companya de la companya de | | |
| .00 | ADMINISTRATIVE & GENERAL | 5.00 | o | 1 1 7 0 | | | | |
| .00 | OPERATING ROOM | 50.00 | 0 | 1,150 16,953 | 0 | | | 1.00 |
| .00 | EMERGENCY | 91.00 | o | 12,117 | 0 | 1 | | 2.00 |
| .00 | CAFETERIA | 11.00 | o | 535 | 0 | | | 3.00 |
| .00 | PHYSICIANS' PRIVATE OFFICES | 192.00 | o | 39,722 | 0 | 1 | | 4.00 |
| | TOTALS | | o | 70,477 | • | | | 5.00 |
| | J - BILLABLE SUPPLIES | | | remain Translation | | | | |
| .00 | ADULTS & PEDIATRICS | 30.00 | 0 | 6,206 | 0 | İ | | 1.00 |
| .00 | INTENSIVE CARE UNIT | 31.00 | 0 | 242 | 0 | | | 2.00 |
| .00 | OPERATING ROOM | 50.00 | 0 | 36,965 | 0 | | | 3.00 |
| .00 | RADIOLOGY-DIAGNOSTIC | 54.00 | 0 | 56 | 0 | | | 4.00 |
| .00 | RESPIRATORY THERAPY PHYSICAL THERAPY | 65.00 | 0 | 46 | 0 | | | 5.00 |
| .00 | OCCUPATIONAL THERAPY | 66.00 | 0 | 287 | 0 | | | 6.00 |
| .00 | DRUGS CHARGED TO PATIENTS | 67.00 | 0 | 23 | 0 | | | 7.00 |
| .00 | CLINIC | 73.00 90.00 | 0 | 8 | 0 | | | 8.00 |
| 0.00 | EMERGENCY | 91.00 | 0 | 153 2,454 | 0 | | | 9.00 |
| 1.00 | AMBULANCE SERVICES | 95.00 | 0 | 1,305 | - | | | 10.00 |
| 2.00 | HOME HEALTH AGENCY | 101.00 | 0 | 6,823 | 0 0 | | | 11.00 |
| 3.00 | PHYSICIANS' PRIVATE OFFICES | 192.00 | o | 22,388 | n | | | 12.00 |
| | TOTALS | | ō | 76,956 | | | | 13.00 |
| | K - PLANT COST | | .3 | • • 1 | | | | ĺ |
| .00 | AMBULANCE SERVICES | 95.00 | 0 | 3,316 | 0 | | | 1.00 |
| .00 | PHYSICIANS' PRIVATE OFFICES | 192.00 | 0 | 81,126 | . 0 | | | 2.00 |
| | TOTALS | | 0 | 84,442 | | | | 00 |
| | M - YELLOW PAGES MARKETING | 202 53 | 1 | | | | | |
| | TOTALS | 192.01 | 0 | 32,263 | 0 | | | 1.00 |
| | P - IMPLANTABLE DEVICE | | 0 | 32,263 | | | | |
| | MEDICAL SUPPLIES CHARGED TO | 71 00 | | | | | | |
| | PATIENTS CHARGED TO | 71.00 | 0 | 49,722 | 0 | | | 1.00 |
| | TOTALS | | o | 49,722 | - | | | |
| i i | R - PAYROLL | | VI | 73,722 | | | estate and the second | |
| .00 | EMPLOYEE BENEFITS | 4.00 | 0 | 4,381,374 | 0 | | | |
| 00 | | 0.00 | o | 0 | 0 | | | 1.00 |
| 00 | on water | 0.00 | o | ő | 0 | | | 2.00 |
| 00 | | 0.00 | o | o | 0 | | | 3.00 |
| 00 | | 0.00 | Ō | ŏ | 0 | | | 4.00 5.00 |
| 00 | | 0.00 | o | 0 | Ŏ | | | 6.00 |
| 00 00 | | 0.00 | o | 0 | ŏ | | | 7.00 |
| . 34 5 | | 0.00 | O | o | ŏ | | | 8.00 |
| | 1 | 0.00 | o | 0 | 0 | | | |
| 00 | and the second s | | o _i | O _i | Oi. | | | ุ ฯ กก |
| | | 0.00 | 0 | 0 | 0 | | | 9.00 |

| RECLASSIFICATIONS | | PERRY COUNTY | | CCN: 151322 | Period: | u of Form CMS-2552-1 Worksheet A-6 |
|--|-----------|---|-----------|---------------|----------------------------------|---------------------------------------|
| | | | | | From 01/01/2012 To 12/31/2012 | Date/Time Prepared |
| And the second s | Decreases | Will the Thirt was record and the second second | | | L | 5/30/2013 9:13 am |
| Cost Center | Line # | Salary | Other | Wkst. A-7 Ref | :_ | |
| 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | | 1 |
| 13.00 | 0.00 | 0 | 0 | | 0 | 13.0 |
| 14.00 | 0.00 | o | Õ | | 0 | 14.0 |
| 15.00 | 0.00 | o | Õ | | 0 | |
| 16.00 | 0.00 | 0 | Ŏ | | 0 | 15.0 |
| 17.00 | 0.00 | 0 | 0 | | 0 | 16.0 |
| 18.00 | 0.00 | 0 | 0 | | 0 | 17.0 |
| 19.00 | 0.00 | o o | 0 | | | 18.0 |
| 20.00 | 0.00 | 0 | 0 | | 0 | 19.0 |
| 21.00 | 0.00 | Ŏ | 0 | | 0 | 20.0 |
| 22.00 | 0.00 | 0 | 0 | | | 21.0 |
| 23.00 | 0.00 | 0 | 0 | | 0 | 22.0 |
| 24.00 | 0.00 | 0 | 0 | | 0 | 23.0 |
| 25.00 | 0.00 | 0 | , n | | 0 | 24.0 |
| 26.00 | 0.00 | 0 | 0 | | 0 | 25.0 |
| TOTALS | | | 4,381,374 | | ŭ | 26.0 |
| S - DEPRECIATION | 1 | 9 | 7,301,3/4 | | . I | |
| 00 PHYSICIANS' PRIVATE OFFICES | 192.00 | o] | 136,316 | r | al | |
| TOTALS | 132.00 | | | | 9 | 1.0 |
| 00.00 Grand Total: Decreases | | 70 517 | 136,316 | | - | |
| , | ! | 79,517 | 5,144,901 | | | 500.0 |

| Health | Financial Systems | PERRY COUNTY | HOSPITAL | | | In Lie | u of Form CMS-2 | 2552-10 |
|--------|--|-----------------------|-------------|-------------|--------------------------------|--------------------|------------------------------|---------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provider C | CN: 151322 | Period: From 01/0 To 12/ | 01/2012 31/2012 | | pared: |
| | | | | Acquisition | S | | | |
| | | Beginning Balances | Purchases | Donation | Tot | | Disposals and Retirements | |
| | * pro-site contracts Advisory and a second pro-site contract of the contract o | 1.00 | 2.00 | 3.00 | 4.1 | 00 | 5.00 | |
| | PART I - ANALYSIS OF CHANGES IN CAPITA | L ASSET BALANCES | | | | | | |
| 1.00 | Land | 2,945,631 | 0 | | 0 | 0 | 0 | 1.00 |
| 2.00 | Land Improvements | 1,494,906 | 0 | | 0 | 0 | 0 | 2.00 |
| 3.00 | Buildings and Fixtures | 10,365,854 | 0 | | 0 | 0 | 0 | 3.00 |
| 4.00 | Building Improvements | 0 | 0 | | 0 | 0 | 0 | 4.00 |
| 5.00 | Fixed Equipment | 8,308,100 | 1,020,377 | | 0 1, | 020,377 | 1,156,964 | 5.00 |
| 6.00 | Movable Equipment | 9,428,179 | 1,287,861 | | 0 1, | 287,861 | 90,068 | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | | 0 | 0 | . 0 | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 32,542,670 | 2,308,238 | | 0 2, | 308,238 | 1,247,032 | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | | 0 | . 0 | . 0 | 9.00 |
| 10.00 | Total (line 8 minus line 9) | 32,542,670 | 2,308,238 | | 0 2. | 308.238 | 1,247,032 | 10.00 |
| | And the second test of the secon | Ending Balance | Fully | | | • | | |
| | | | Depreciated | | | | | |
| | | | Assets | | | | | |
| | 2 1 10 10 10 10 10 10 10 10 10 10 10 10 1 | 6.00 | 7.00 | | | | | |
| | PART I - ANALYSIS OF CHANGES IN CAPITA | L ASSET BALANCES | | | | | | |
| 1.00 | Land | 2,945,631 | 0 | | | | | 1.00 |
| 2.00 | Land Improvements | 1,494,906 | 0 | | | | | 2.00 |
| 3.00 | Buildings and Fixtures | 10,365,854 | 0 | | | | | 3.00 |
| 4.00 | Building Improvements | 0 | 0 | | | | | 4.00 |
| 5.00 | Fixed Equipment | 8,171,513 | 0 | | | | | 5.00 |
| 6.00 | Movable Equipment | 10,625,972 | 0 | | | | | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | | | | | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 33,603,876 | 0 | | | | | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | | | | | 9.00 |
| 10.00 | Total (line 8 minus line 9) | 33,603,876 | 0 | | | | | 10.00 |

| | h Financial Systems | PERRY COUNTY | HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|-------|--|------------------------------|---------------|-------------|---|--|---------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | gets remainded in the second | Provider (| CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part II | pared: |
| | | | SU | MMARY OF CA | PITAL | | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance (see instructions) | | |
| | ** Compression of the communication of the communic | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| | PART II - RECONCILIATION OF AMOUNTS FROM | WORKSHEET A, COLUMN | 2, LINES 1 an | nd 2 | er var er de veren er en en er er er en en en en en en en en en en en en en | - Andrew Co. C. C. C. C. C. C. C. C. C. C. C. C. C. | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 1,062,349 | 0 | | 0 0 | 0 | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | 0 0 | ñ | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 1,062,349 | Ō | | 0 0 | Ô | 3.00 |
| | | SUMMARY OF | CAPITAL | | o ₁ | | 3.00 |
| | Cost Center Description | | otal (1) (sum | | | | |
| | | | of cols. 9 | | | | |
| | | d Costs (see instructions) | through 14) | | | | |
| | the second secon | 14.00 | 15.00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM | WORKSHEET A, COLUMN | 2, LINES 1 an | d 2 | | The second secon | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 0 | 1,062,349 | | | | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 1,062,349 | | | | 3.00 |

| Health Financial Systems RECONCILIATION OF CAPITAL COSTS CENTERS | PERKI COUN | TY HOSPITAL | T | | u of Form CMS-2 | :552-I |
|--|--------------|--|--|---|---|-----------------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | Provider | · CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part III Date/Time Prep 5/30/2013 9:13 | |
| | CO | MPUTATION OF RA | TIOS | ALLOCATION OF | | |
| Cost Center Description | Gross Assets | Capitalized Leases | Gross Assets for Ratio (col. 1 - col 2) | instructions) | Insurance | |
| The same of the sa | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| PART III - RECONCILIATION OF CAPITAL COST | S CENTERS | | made a superior of the superio | . Takin ta in tinin yi yi samamasanin d | A DE LE LE LE LE LE LE LE LE LE LE LE LE LE | *** **** |
| 1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP | | 1 | 0 | 1 1.000000 | 0 | 1.00 |
| 3.00 Total (sum of lines 1-2) | | 0 | 0 | 0.000000 | 0 | 2.00 |
| 3.00 Hocal (Suit Of Titles 1-2) | | 1 | Ψ •••••• | 1 1.000000 | 0 | 3.00 |
| | ALLOCA | ATION OF OTHER | CAPITAL | SUMMARY O | F CAPITAL | |
| Cost Center Description | Taxes | Other Capital-Relate d Costs | Total (sum o cols. 5 through 7) | f Depreciation | Lease | re i myrey in . |
| A STATE OF THE STA | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| PART III - RECONCILIATION OF CAPITAL COST | S CENTERS | . The same appropriate the same appropriate to the sam | enter a communication of the c | to a second of a second | | |
| 1.00 NEW CAP REL COSTS-BLDG & FIXT | | 0 | D | 0 1,190,138 | 0 | 1.00 |
| 2.00 NEW CAP REL COSTS-MVBLE EQUIP | | 0 | O | 0 -12,184 | 105,436 | 2.00 |
| 3.00 Total (sum of lines 1-2) | (| 0 | O | 0 1,177,954 | 105,436 | 3.00 |
| | | S | UMMARY OF CAPI | TAL | | |
| Cost Center Description | Interest | Insurance (see | Taxes (see | Other | Total (2) (sum | |
| · | | instructions) | instructions | Capital-Relate d Costs (see instructions) | of cols. 9 through 14) | |
| DAST TITE DECOMET TATTON OF | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| PART III - RECONCILIATION OF CAPITAL COST. 1.00 NEW CAP REL COSTS-BLDG & FIXT | S CENTERS | -i | -1 | _1 | | |
| 2.00 NEW CAP REL COSTS-BLDG & FIXT | 9 | 0 | 0 | 0 0 | 1,190,138 | 1.00 |
| 3.00 Total (sum of lines 1-2) | | 0 |) | 0 | 93,252 | 2.00 |
| iocai (sum oi iilles 1-2) | - 1 | U (| J | 0 | 1.283.390 | 3.00 |

Provider CCN: 151322

Period: From 01/01/2012 To 12/31/2012

Worksheet A-8 Date/Time Prepared: 5/30/2013 9:13 am

| 3 | | | | Expense Classification on To/From Which the Amount is | | 5/30/2013 9:1 | 4111 |
|---------------|--|----------------|-----------------|--|----------------|---|--------------|
| | Cost Center Description | Basis/Code (2) | Amount 2.00 | Cost Center | Line # 4.00 | Wkst. A-7 Ref. 5.00 | |
| 1.00 | Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter | i 'I | | NEW CAP REL COSTS-BLDG & | 1.00 | | 1.0 |
| 2.00 | 2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter | В | -21,874 | NEW CAP REL COSTS-MVBLE EQUIP | 2.00 | 10 | 2.0 |
| 3.00 | 2) Investment income - other (chapter 2) | | 0 | | 0.00 | 0 | 3.0 |
| 1.00 | Trade, quantity, and time discounts (chapter 8) | - | . 0 | | 0.00 | 0 | 4.0 |
| .00 | Refunds and rebates of expenses (chapter 8) | | 0 | | 0.00 | 0 | 5.0 |
| 5.00 | Rental of provider space by suppliers (chapter 8) | | 0 | | 0.00 | 0 | 6.0 |
| 7.00 | Telephone services (pay stations excluded) (chapter | | O | | 0.00 | 0 | 7.0 |
| 3.00 | 21) Television and radio service (chapter 21) | | 0 | | 0.00 | 0 | 8.0 |
| 0.00 10.00 | Parking lot (chapter 21) Provider-based physician | A-8-2 | 0 -1,786,211 | | 0.00 | 0 | |
| | adjustment Sale of scrap, waste, etc. | | 0 | | 0.00 | | |
| 2.00 | (chapter 23) Related organization | A-8-1 | 28,570 | | | 0 | 12.0 |
| | transactions (chapter 10) Laundry and linen service | | 0 | | 0.00 | 0 | 13.0 |
| | Cafeteria-employees and guests Rental of quarters to employee and others | | -50,188 0 | CAFETERIA | 11.00 0.00 | | 14.0 15.0 |
| 16.00 | Sale of medical and surgical supplies to other than patients | В | -86,229 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 71.00 | О | 16.0 |
| | Sale of drugs to other than patients | В | -1,568 | DRUGS CHARGED TO PATIENTS | 73.00 | 0 | 17.0 |
| | Sale of medical records and abstracts | В | -3,748 | MEDICAL RECORDS & LIBRARY | 16.00 | 0 | 18.0 |
| | Nursing school (tuition, fees, books, etc.) | | 0 | | 0.00 | | 19.0 |
| | Vending machines Income from imposition of interest, finance or penalty charges (chapter 21) | | 0 | | 0.00 | | |
| 22.00 | Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments | | 0 | | 0.00 | o | 22.0 |
| !3.00 | therapy costs in excess of limitation (chapter 14) | A-8-3 | 0 | RESPIRATORY THERAPY | 65.00 | | 23.0 |
| 24.00 | Adjustment for physical therapy costs in excess of limitation (chapter 14) | A-8-3 | 0 | PHYSICAL THERAPY | 66.00 | 2000 | 24.0 |
| 5.00 | Utilization review - physicians' compensation (chapter 21) | | 0 | *** Cost Center Deleted *** | 114.00 | PROGRAM AND AND AND AND AND AND AND AND AND AND | 25.0 |
| 6.00 | Depreciation - NEW CAP REL COSTS-BLDG & FIXT | | | NEW CAP REL COSTS-BLDG & | 1.00 | 0 | 26.0 |
| | Depreciation - NEW CAP REL COSTS-MVBLE EQUIP | | 0 | NEW CAP REL COSTS-MVBLE EQUIP | 2.00 | 0 | 27.0 |
| | Non-physician Anesthetist Physicians' assistant | - | 0 | *** Cost Center Deleted *** | 19.00 0.00 | · · · · · · · · · · · · · · · · · · · | 28.0 |
| 0.00 | Adjustment for occupational therapy costs in excess of limitation (chapter 14) | A-8-3 | 0 | OCCUPATIONAL THERAPY | 67.00 | - ; | 29.0 30.0 |
| 1.00 | Adjustment for speech pathology costs in excess of | A-8-3 | 0 | SPEECH PATHOLOGY | 68.00 | | 31.0 |
| 2.00 | limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest | A | | NEW CAP REL COSTS-BLDG & | 1.00 | 9 | 32.0 |
| 3 00 | MISC INCOME | В | | FIXT ADMINISTRATIVE & GENERAL | 5.00 | 0 | 33.0 |

| | Financial Systems MENTS TO EXPENSES | | PERRY COUNT | Provider CCN: 151322 | Period: | worksheet A-8 | |
|-------|--|--|-------------|--|--|--------------------------------|----------------|
| | | | | | From 01/01/2012 | | |
| | | | | and the second s | To 12/31/2012 | Date/Time Pre 5/30/2013 9:1 | pared: 3 am |
| | - The second sec | | | Expense Classification | on Worksheet A | | |
| | | - I de la company de la compan | | To/From Which the Amount | is to be Adjusted | | |
| | | | | | | | |
| | Cost Center Description | property of the first transfer to the factor of the factor | Amount | Cost Center | AT THE RESERVE OF THE PERSON OF THE PARTY AND THE PARTY AN | Wkst. A-7 Ref. | |
| _ : : | ************************************** | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | MISC INCOME | В | | AMBULANCE SERVICES | 95.00 | | 34.00 |
| 35.00 | MISC INCOME | В | | HOME HEALTH AGENCY | 101.00 | | |
| 36.00 | HHA ADVERTISING | A | | HOME HEALTH AGENCY | 101.00 | - | 36.00 |
| 37.00 | RECRUITING | Α | -54,991 | ADMINISTRATIVE & GENERAL | 5.00 | - | 37.00 |
| 38.00 | | | 0 | | 0.00 | 0 | 38.00 |
| 39.00 | SWAP INTEREST | A | • | NEW CAP REL COSTS-MVBLE EQUIP | 2.00 | 9 | 39.00 |
| 40.00 | | Α | -22,764 | OPERATION OF PLANT | 7.00 | 0 | 40.00 |
| 41.00 | PHONE | A | | NEW CAP REL COSTS-BLDG & FIXT | 1.00 | 9 | 41.00 |
| | DIETARY | В | -41 | DIETARY | 10.00 | 0 | 42.00 |
| | AHS | A | -3,718 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 43.00 |
| 45.00 | NON-ALLOWABLE EXPENSE | A | -34,521 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 45.00 |
| 45.01 | | В | 5,391 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 45.01 |
| | MISCELLANEOUS EXPENSE | Α . | -12,833 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 45.02 |
| | HOSPICE | Α | -8 | HOSPICE | 116.00 | 0 | 1 |
| 50.00 | TOTAL (sum of lines 1 thru 49) | | -2,247,931 | | | - | 50.00 |
| | (Transfer to Worksheet A, | | | | | | |
| | column 6. line 200.) | | | | | i · | |

| | MENT OF COSTS OF SERVICES FROM E COSTS | RELATED ORGANIZATIONS AND | HOME Provider CCN: | | | 3-1 epared: |
|-----------------|---|--|---|------------------------------|--------------------------------------|---------------------------------|
| | Line No. | Cost Center | Expense Iter | ms Amount of Allowable Co | Amount | promo aprili i distrizza da que |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | A. COSTS INCURRED AND ADJUST HOME OFFICE COSTS: | MENTS REQUIRED AS A RESULT | OF TRANSACTIONS WITH F | RELATED ORGANIZATIONS | OR CLAIMED | |
| 1.00 | 2.00 | NEW CAP REL COSTS-MVBLE EOUIP | AMBULANCE DEPRECIAT | ION 32, | 519 0 | 1.00 |
| 2.00 3.00 | 0.00 | RADIOLOGY-DIAGNOSTIC | MOBILE MRI | 324,: | 281 328,330 0 0 | 2.00 3.00 |
| 4.00 | 0.00 | | | | 0 0 | 4.00 |
| 5.00 | 0 e amounts on lines 1-4 (and sub | | 0 | 356,9 | | 5.00 |
| | oriate. Positive amounts incre | ease cost and negative amoun eet A. columns 1 and/or 2. 1 | nts decrease cost. Fo the amount allowable s | hould be indicated in | n or home office of column 4 of this | cost |
| approj which | nas not been posted to workshe Symbol (1) | Name | Rela | ted Organization(s) an | nd/or Home Office | part. |
| approj which | Symbol (1) | Name | Percentage of Ownership | | Percentage of Ownership | part. |
| approj which | | Name 2.00 | Percentage of Ownership 3.00 | | nd/or Home Office | part. |

non-financial) specify: (1) use the following symbols to indicate interrelationship to related organizations:

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OTHER

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

 B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

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| | | ERVICES FROM RELAT | ED ORGANIZATIONS AND HOME | Provider CCN: 151322 | Period: From 01/01/2012 | Worksheet A | -8-1 |
|---------------------|---|--|---|--|--|--|--|
|)++1CE | E COSTS | | | | To 12/31/2012 | Date/Time P 5/30/2013 9 | |
| 15 Shall I a shall | Net Wk Adjustments (col. 4 minus col. 5)* | st. A-7 Ref. | | | androne, me commercial meteorical for a series of the seri | ing for the first of the second of the secon | |
| #** . #**** . ****. | 6.00 | 7.00 | | | | | |
| | A. COSTS INCURRED HOME OFFICE COSTS | | REQUIRED AS A RESULT OF TR | RANSACTIONS WITH RELATED | ORGANIZATIONS OR | CLAIMED | |
| .00 | 32,619 | 10 | | | | | 1.0 |
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| .00 | 28,570 | | | manufacture and a second secon | | | 5.0 |
| prop | oriate. Positive a | umounts increase co ed to Worksheet A, zation(s) | ts as appropriate) are tra ost and negative amounts d columns 1 and/or 2, the a | ecrease cost. For relate | ed organization or | home office | |
| | Type of Bu | siness | | | | | The standard of the standard o |

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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| 100.00 | 100.00 |

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

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| 00121 | NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS | FURNISHED BY | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 Parts I-VI Date/Time Pre 5/30/2013 9:1 | pared |
|--|--|--|--|--|--|--|--|
| | | | | | Physical Therapy | | 1 |
| | por many and the second | tion and a few sames are a series of the series of | And region arrange from the passage of the control of | The second secon | one and a transfer property | 1.00 | |
| 1.00 | PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide | s) (see instruc | tions) | a transmission of the second | *************************************** | 52 | 1.0 |
| 2.00 | Line 1 multiplied by 15 hours per week | | | | | 780 | |
| 3.00 | Number of unduplicated days in which supervi | sor or therapist | t was on provi | der site (see | instructions) | 359 | |
| 4.00 | Number of unduplicated days in which therapy | assistant was o | on provider si | te but neithe | r supervisor | 0 | 4.0 |
| 5.00 | nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe | ructions) ruisors or ther | anists (soo in | r+muc+ionc) | | 40 | |
| 6.00 | Number of unduplicated offsite visits - there assistant and on which supervisor and/or the instructions) | apv assistants (| (include only v | visits made b | y therapy) (see | 48 935 | 5.(6.(|
| 7.00 | Standard travel expense rate | | | | | 5.50 | ! |
| 8.00 | Optional travel expense rate per mile | Supervisors | Thousanders | - ~ | 1 44.41.1 | 0.00 | 8.0 |
| | | 1.00 | Therapists 2.00 | Assistants 3.00 | Aides 4.00 | Trainees 5.00 | |
| | Total hours worked | 0.00 | 3,349.00 | 5,660.0 | material and the second of the | Beautiful Committee and the second control of the | 9.1 |
| | AHSEA (see instructions) | 0.00 | 72.00 | 54.0 | 0.00 | 0.00 | |
| 11.00 | Standard travel allowance (columns 1 and 2, | 36.00 | 36.00 | 27.0 | 0 | | 11.0 |
| | one-half of column 2, line 10; column 3, one-half of column 3, line 10) | | | | | | |
| 12.00 | Number of travel hours (provider site) | 0 | 133 | 17 | 4 | | 12. |
| 12.01 | Number of travel hours (offsite) | 0 | 0 | | 0 | | 12. |
| 13.UU | Number of miles driven (provider site) Number of miles driven (offsite) | 0 | 4,955 | 8,27 | - 1 | | 13. |
| 13.01 | Number of mites driven (offsite) | 0 | | | 0 | The second secon | 13. |
| | | | | | | 1.00 | |
| | Part II - SALARY EQUIVALENCY COMPUTATION | | The second companies with the second companies of the second companies with the second companies of th | | . The second section of the section of the section | | |
| 14.00 | Supervisors (column 1, line 9 times column 1, | , line 10) | | | | | 14. |
| 6.00 | Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, | line 10) | | | | 241,128 | |
| 7.00 | Subtotal allowance amount (sum of lines 14 ar | nd 15 for resnir | atory therany | or lines 14- | 16 for all | 305,640 546,768 | |
| | otners) | | acor, enerupy | 01 111103 14 | 10 101 411 | 340,708 | 17. |
| 18.00 | Aides (column 4, line 9 times column 4, line | 10) | | | | _ 3 | |
| 19.00 | | | | | | 0 | 18.0 |
| 20 00 | Trainees (column 5, line 9 times column 5, li | ine 10) | -h | 17 10 | 5 33 | 0 | 18.0 19.0 |
| 20.00 | Total allowance amount (sum of lines 17-19 fo | ine 10) or respiratory t | herapy or line | es 17 and 18 | for all others) | 0 546 768 | 19.0 |
| 20.00 | Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than | ine 10) or respiratory t or therapy or col or line 2. make n | umns 1-3 for r | bysical ther | anv. speech nath | 0 546,768 | 19.0 |
| 20.00 | Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete | ine 10) or respiratory t or therapy or col or line 2, make n lines 21-23. | umns 1-3 for p o entries on 1 | hysical ther ines 21 and | apy, speech path 22 and enter on | 0 546,768 | 19. |
| 20.00 | Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and tra | ine 10) or respiratory t v therapy or col l line 2, make n lines 21-23. ainees (line 17 | umns 1-3 for p o entries on l | hysical ther ines 21 and | apy, speech path 22 and enter on | 0 546,768 | 19.0 20.0 |
| 20.00 | Total allowance amount (sum of lines 17-19 for if the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traffer respiratory therapy or columns 1 thru 3. | ine 10) or respiratory t or therapy or col or line 2, make n lines 21-23. ainees (line 17 | umns 1-3 for poor on 1 divided by sun | hysical ther ines 21 and | apy, speech path 22 and enter on | 0 546,768 nology or line 23 | 19.0 20.0 |
| 20.00 | Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) | ine 10) or respiratory to or therapy or col or line 2, make n lines 21-23. sinees (line 17 line 9 for all ees (line 2 time | umns 1-3 for poor entries on 1 divided by sun others) es line 21) | physical ther ines 21 and of columns | apy, speech path 22 and enter on 1 and 2, line 9 | 0 546,768 nology or line 23 0.00 | 19. 20. 21. |
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| 20.00 21.00 22.00 23.00 | Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD TRAVEL ALLOW TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW TRAVEL ALLOW STANDARD TRAVEL ALLOW T | ine 10) or respiratory to or therapy or col or line 2, make n lines 21-23. sinees (line 17 line 9 for all ees (line 2 time | umns 1-3 for poor entries on 1 divided by sun others) es line 21) | physical ther ines 21 and of columns | apy, speech path 22 and enter on 1 and 2, line 9 | 0 546,768 nology or line 23 0.00 0 546,768 | 21.6 22.6 23.6 24.6 |
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| 21.00 21.00 22.00 23.00 24.00 25.00 27.00 28.00 29.00 90.00 1.00 | Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trained to the standard allowance excluding aides and trained to the standard travel Allowance. Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or | ine 10) or respiratory to therapy or column 2, make no line 2, make no line 9 for all less (line 2 times times 24 for respiratory travel expense follows 1 and line 12) sum of lines 29 for lines 29 for lines 29 for lines 29 for lines 29 sum of lines 29 sum of lines 29 | umns 1-3 for po entries on 1 divided by sum others) ss line 21) EXPENSE COMPUTE and 25 for all therapy or sum at the provide 2, line 12) | thysical ther ines 21 and in of columns TATION - PRO I others) Im of lines 3 It site (sum in the site) | apy, speech path 22 and enter on 1 and 2, line 9 VIDER SITE and 4 for all of lines 26 and | 0,000 546,768 0,000 0,546,768 12,924 0,12,924 1,975 14,899 9,576 9,396 18,972 | 21.4. 22.6. 23.6. 24.6. 25.6. 27.6. 28.6. 29.6. 30.6. 31.6. |
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| 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 6.00 7.00 8.00 | Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel Assistants (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Expense Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Optional travel expense (line 8 times the sum Optional travel expense (line 8 times the sum Optional travel expense (line 8 times the sum Optional travel expense (line 8 times the sum Optional travel expense (line 8 times the sum Optional travel expense (line 8 times the sum Optional travel expense (line 8 times the sum Optional travel expense (line 8 times the sum Optional Travel Allowance and Travel Expense - Optional Travel Allowance and Travel Expense - Optional Travel Allowance and Travel Expense - Optional Travel Allowance and Travel Expense - Optional Travel Allowance and Travel Expense - Optional Travel Allowance and Travel Expense - Optional Travel A | ine 10) or respiratory to therapy or colonine 2, make no line 2, make no line 2 line 2 line 9 for all lines (line 17 line 9 for all lines (line 2 time 2 line 2 line 2 line 2 line 2 line 2 line 2 line 2 line 2 line 2 line 2 line 2 line 2 line 3 line 12) sum of lines 2 line 3 line 1 line 5 and 2 line 3 line 1 line 5 and 2 line 3 line 1 line 5 and 2 line 3 line 1 line 5 and 2 line 3 line 1 line 5 and 2 line 3 line 1 line 5 and 2 line 3 line 1 line 5 and 2 line 3 line 1 line 5 and 2 line 3 line 1 line 5 and 2 line 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 line 5 and 3 line 1 lines 5 and 3 line 1 lines 5 and 3 line 1 lines 5 and 3 line 1 lines 5 and 3 lines 1 lines 3 | umns 1-3 for po entries on 1 divided by sun others) is line 21) EXPENSE COMPUTATION of all therapy or sure at the provided 2, line 12) and 30 for all 13 for respiral 28) for lines 31 and EXPENSE COMPUTATION of 10 c), line 13.01) c; Complete one for lines 38 and for the same and the complete one for lines 38 and for the same and the complete one for lines 38 and for the same and the complete one for lines 38 and for the same and the complete one for lines 38 and for the complete one for lines 38 and for the complete one for lines 38 and for the complete one for lines 38 and for the complete one for lines 38 and for the complete one for lines 38 and for the complete one for lines 38 and for the complete one for lines 38 and for the complete one for lines 38 and for the complete one for lines 38 and for the complete one for lines 38 and for lines | of the follows | apy, speech path 22 and enter on 1 and 2, line 9 VIDER SITE and 4 for all of lines 26 and or sum of ICES OUTSIDE PRO | 0,000 0,546,768 0,000 0,546,768 12,924 0,12,924 1,975 14,899 9,576 9,396 18,972 0 0 0,00 18,972 VIDER SITE 1,728 25,245 26,973 5,407 | 21. 22. 23. 24. 25. 26. 27. 28. 33. 33. 33. 33. 33. 33. 33. 33. 33. 3 |

| 49.40 Otal overtime (including base and overtime allowance) (multiply) line 47 times line 45 O.00 O | | ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS | FURNISHED BY | Provider | f | Period: From 01/01/2012 To 12/31/2012 | 5/30/2013 9:1 | pared: |
|--|--------|--|--|---------------------------------|--|---|--|---|
| A6.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions) | | The second section of the second seco | The second secon | | | nysical inerapy | Management and the second | *************************************** |
| Therapists | 46.00 | Optional travel allowance and optional travel | expense (sum c | of lines 42 and | 1 43 - see ins | tructions | | 46.00 |
| ### PART V - OVERTIME COMPUTATION 1.00 2.00 3.00 4.00 5.00 ### A7.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or complete lines after than 2,880, do not compl | | C. ave | | | | | - North - Andrew Street, Spilling and Street, | 40.00 |
| 47.00 overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 55) 48.00 overtime rate (see instructions) 49.00 local overtime (including base and overtime 0.00 0.00 0.00 0.00 0.00 0.00 49. 48.00 overtime (including base and overtime 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0. | | The second secon | 1.00 | 2.00 | 3.00 | 4.00 | and the second of the second segments of the second of the second | |
| period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56] and on the complete lines 48-55 and enter zero in each column of line 56] and overtime rate (see instructions) 9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 48, 48, 49, 49, 49, 49, 49, 49, 49, 49, 49, 49 | 47.00 | | | | | | | |
| 13.00 | 47.00 | period (if column 5, line 47, is zero or equal to or greater than 2,080, do not | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 47.00 |
| 10 10 10 10 10 10 10 10 | | column of line 56) | | | | | | |
| allowance) (multiply line 47 times line 48) | | | : | | | 1 | | 48.00 |
| (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) \$1.00 | 19.00 | allowance) (multiply line 47 times line 48) | 0.00 | 0.00 | 0.00 | 0.00 | | 49.00 |
| 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOMANCE 52.00 'Adjusted hourly salary equivalency amount (see instructions) S3.00 overtime cost limitation (line 51 times line 52) 53.00 overtime cost limitation (line 51 times line 52) 54.00 Maximum overtime cost (enter the lesser of line 49 or line 53) 55.00 Portion of overtime already included in hourly computation at the AMSEA (multiply line 47 times line 52) 56.00 Overtime allowance (line 54 minus line 55 - 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 50.00 | (divide the hours in each column on line 47 by the total overtime worked - column 5, | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 50.00 |
| DETERMINATION OF OVERTIME ALLOMANCE 2.00 Allow | 51.00 | Allocation of provider's standard work year for one full-time employee times the | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 51.00 |
| (see instructions) 33.00 overtime cost limitation (line 51 times line 0 0 0 0 0 0 0 0 53. 53. 54. 55. 56. 57. 58. 68. 69. 60. 60. 60. 60. 60. 60. 60 | | DETERMINATION OF OVERTIME ALLOWANCE | · | | ****** | 4 | | |
| 52) 54.00 Maximum overtime cost (enter the lesser of line 49 or line 53) 55.00 Portion of overtime already included in hourly computation at the AMSEA (multiply line 47 times line 52) 56.00 Overtime allowance (line 54 minus line 55 - o o o o o o o o o o o o o o o o o | | (see instructions) | | | | | ************************************** | 52.00 |
| line 49 or line 53) 55.00 Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52) 66.00 Overtime allowance (line 54 minus line 55 - 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 52) | J | | | ' ' | | 33.00 |
| hourly computation at the AHSEA (multiply line 47 times line 52 in 6.00 Overtime allowance (line 54 minus line 55 if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 7.00 Salary equivalency amount (from line 23) 8.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 9.00 Travel allowance and expense - provider site (from lines 44, 45, or 46) 9.00 Overtime allowance (from column 5, line 56) 9.00 Overtime allowance (from column 5, line 56) 9.00 Supplies (see instructions) 9.00 Supplies (see instructions) 9.00 Total allowance (sum of lines 57-62) 9.00 Supplies (see instructions) 9.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION 9.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 9.00 LINE 34 CALCULATION 1.01 Column 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 9.01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 1.975 100. 1.10 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1.975 101. 1.10 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 1.8,972 102. 1.10 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line | | line 49 or line 53) | 0 | | _ | | | 54.00 |
| if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 7.00 Salary equivalency amount (from line 23) 8.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 18,972 58. 90.00 Overtime allowance and expense - offsite services (from lines 44, 45, or 46) 0 Equipment cost (see instructions) 1.00 Equipment cost (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (from your records) 5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION 0.00.01 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 0.00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 0.10.01 Line 31 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 0.1.01 Line 31 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 1.975 100. 1.10.01 Line 31 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 1.975 100. 1.10.01 Line 31 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 1.975 100. 1.10.01 Line 31 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 1.975 100. 1.10.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1.975 100. 1.10.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1.975 100. 1.10.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1.975 101. 1.10.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1.975 101. 1.10.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others | | hourly computation at the AHSEA (multiply line 47 times line 52) | U _I | U | C | 0 | | 55.00 |
| Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 1.00 | 56.00 | if negative enter zero) (Enter in column 5 | 0 | 0 | 0 | 0 | 0 | 56.00 |
| Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT Salary equivalency amount (from line 23) 18.902 | | respiratory therapy and columns 1 through 3 | | | 989 8 - C. C. C. C. C. C. C. C. C. C. C. C. C. | | | |
| 18,90 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 18,972 58. 18,972 102. 19,973 58. 18,972 102. 19,973 58. 18,972 102. 19,973 58. 18,972 102. 19,973 58. 18,972 102. 19,973 58. 18,972 102. 19,973 58. 18,972 102. 19,973 58. 18,972 102. 19,973 58. 18,972 103. 19,973 58. 18,972 103. 19,973 103. | - | Part VI - COMPUTATION OF THERAPY LIMITATION A | ND EXCESS COST | ADJUSTMENT | | | 1.00 | e. |
| 19.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 10.00 Overtime allowance (from column 5, line 56) 10.00 Equipment cost (see instructions) 10.00 Equipment cost (see instructions) 10.00 Supplies (see instructions) 10.00 Total allowance (sum of lines 57-62) 10.00 Total cost of outside supplier services (from your records) 10.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 10.00 Line 33 CALCULATION 10.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 10.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 10.00 Line 33 = line 28 = sum of lines 26 and 27 10.01 Line 34 CALCULATION 10.01 Line 37 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 10.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 10.02 Line 34 = sum of lines 27 and 31 10.03 Line 35 CALCULATION 10.04 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 10.05 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 10.05 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 10.05 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 10.05 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 10.06 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 10.07 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 10.07 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 10.07 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line | 7.00 | Salary equivalency amount (from line 23) | | | | 7 | 546,768 | 57.00 |
| 0.00 Overtime allowance (from column 5, line 56) 11.00 Equipment cost (see instructions) 12.00 Supplies (see instructions) 13.00 Total allowance (sum of lines 57-62) 14.00 Total cost of outside supplier services (from your records) 15.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION 0.00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 12.924 100. 10.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 12.924 100. 11.NE 34 CALCULATION 11.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 11.975 100. 12.01 Line 31 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 13.975 101. 13.01 Line 35 CALCULATION 14.899 100. 15.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 15.975 101. 16.975 101. 17.21 62. 18.997 101. 18.997 101. 18.997 102. 19.904 101. 19.905 101. 19.907 101. | 9 00 | Travel allowance and expense - provider site | (from lines 33, | 34, or 35)) | | | | |
| 1.00 Equipment cost (see instructions) 2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 3.00 Total cost of outside supplier services (from your records) 5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 01.01 Line 31 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 02.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 18,972 101. 18,972 102. 18,972 102. 18,972 103. 196.470 64. | 0.00 | Overtime allowance (from column 5 line 56) | es (from lines | 44, 45, OF 46) | | | ; | |
| 2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (from your records) 5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 01.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 02.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 18,972 101. 18,972 102. 19,947 101. 102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 103.02 Line 31 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line | 1.00 | Equipment cost (see instructions) | | | | | | |
| 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (from your records) 5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 01.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 02.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 18,972 101. 18,972 102. 19,75 104. 10,947 101. 10,947 101. 11,975 102. 12,924 100. 13, for all others | 2.00 | Supplies (see instructions) | | | | | , , | |
| 4.00 Total cost of outside supplier services (from your records) 5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 1.975 100. 1.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 1.975 101. 1.975 101. 1.975 101. 1.975 101. 1.975 101. 2.01 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 20.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 18,972 101. 20,947 101. 18,972 102. 18,972 103. 18,972 104. 196.470 64. 196.5. 196.470 64. 196.470 65. 196.470 65. 196.470 65. 196.470 65. 196.470 65. 196.470 65. 196.470 65. 196.470 65. 196.470 65. 196.470 65. 196.470 64. 107. 108. 109. 109. 100. | 3.00 | Total allowance (sum of lines 57-62) | | | | | | |
| LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 12,924 100. 10.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 12,924 100. 12,925 100. 13,975 100. 14,899 100. 14,899 100. 15,975 101. 16,975 101. 17,975 101. 18,975 101. 18,975 101. 18,975 101. 18,975 101. 18,975 101. 18,975 101. 18,975 101. 18,975 101. 18,975 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. 20,947 101. | 4.00 | Total cost of outside supplier services (from | your records) | | | | | |
| 00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 01.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 02.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 12,924 100. 14,899 100. 18,975 101. 20,947 101. 20,947 101. 21,975 102. 22,948 100. | J. UU | EXCESS OVER limitation (line 64 minus line 63 | - if negative, | enter zero) | | | 0 | 65.00 |
| 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 31 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 01.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 02.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others | 00.00 | Line 26 = line 24 for respiratory therapy on | sum of lines 24 | and 25 for al | 1 | | 45 45. | |
| U0.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 37 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 01.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1,975 101. 18,972 101. 18,972 101. LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 02.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others | 00.01 | Line 27 = line 7 times line 3 for respiratory | therapy or sum | of lines 3 an | d 4 for all o | thors | | |
| 01.02 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 18,972 101. 20,947 101. 18,972 101. 20,947 101. 18,972 102. 18,972 102. 18,972 102. 18,972 102. 18,972 102. 18,972 102. 18,972 102. 18,972 102. 18,972 102. 18,972 102. | .00.02 | Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION | | | | | | |
| 02.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 18,972 102. 102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others | 01.01 | Line 31 = line 29 for respiratory therapy or : Line 34 = sum of lines 27 and 31 | therapy or sum sum of lines 29 | of lines 3 an and 30 for al | d 4 for all o l others | thers | 18,972 | 101.01 |
| 13 for all others | .02.00 | Line 31 = line 29 for respiratory therapy or state 32 = line 8 times columns 1 and 2, line 3 | sum of lines 29 13 for respirat | and 30 for al ory therapy or | l others sum of colum | ns 1-3, line | 18,972 | 102.00 |
| 40 f 45 f 400 25 | | 13 for all others Line 35 = sum of lines 31 and 32 | , | •, | | , · · · · · | O į | |

| | DE SUPPLIERS | FURNISHED BY | Frovider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 Parts I-VI Date/Time Pre 5/30/2013 9:1 | pared |
|--|--|--|--|--|--|---|---|
| | | | | | Occupational | 7/30/2013 9:1 Cost | o am |
| | And the second s | | | | Therapy | | , |
| | | | | | | 1.00 | |
| | PART I - GENERAL INFORMATION | Terromana de la composición del composición de la composición de la composición del composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la | er en om mormmen i 11 july 14 de en . | reference a service of the service o | | 1.00 | |
| 1.00 | Total number of weeks worked (excluding aide | s) (see instruct | ions) | | | 52 | 1.0 |
| 2.00 | Line 1 multiplied by 15 hours per week | | | | | 780 | į. |
| 3.00 4.00 | Number of unduplicated days in which supervi: Number of unduplicated days in which therapy nor therapist was on provider site (see inst | assistant was o | t was on provic on provider sit | der site (see ce but neithe | instructions) r supervisor | 254 0 | |
| 5.00 6.00 | Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there assistant and on which supervisor and/or the | rvisors or thera apy assistants (| (include only v | isits made b | y therapy) (see | 481 277 | 5.4 6.4 |
| 7.00 | instructions) Standard travel expense rate | | | | | | |
| 8.00 | Optional travel expense rate per mile | | | | | 5.50 | 1 |
| | serional charel expense race pei mile | Supervisors | Therapists | Assistants | Aides | 0.00 Trainees | 8. |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 1 |
| | Total hours worked | 0.00 | 621.00 | 3,020.0 | 1 | 0.00 | 9. |
| | AHSEA (see instructions) | 0.00 | 68.25 | 51.1 | 1 : | 0.00 | |
| 11.00 | Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10) | 34.13 | 34.13 | 25.6 | 60 | | 11. |
| 12.00 | Number of travel hours (provider site) | o | 17 | 26 | 6 | | 12. |
| 12.01 | Number of travel hours (offsite) | 0 | 0 | | 0 | | 12. |
| 13.00 | Number of miles driven (provider site) | 0 | 568 | 7,13 | 5 | | 13. |
| L3.01 | Number of miles driven (offsite) | 0 | 0 | | 0 | ***** | 13. |
| | | | | | | | ļ |
| | Part II - SALARY EQUIVALENCY COMPUTATION | | | | | 1.00 | |
| 4.00 | Supervisors (column 1, line 9 times column 1 | . line 10) | | | | Ó | 14. |
| L5.00 | Therapists (column 2, line 9 times column 2. | line 10) | | | | 42,383 | |
| L6.00 | Assistants (column 3, line 9 times column 3, | line10) | | | | 154,594 | : |
| 17.00 | Subtotal allowance amount (sum of lines 14 ar others) | nd 15 for respir | atory therapy | or lines 14- | 16 for all | 196,977 | 17. |
| 18 00 | Aides (column 4, line 9 times column 4, line | 103 | | | | _ | |
| 19.00 | Trainees (column 5, line 9 times column 5, li | ine 10) | | | | 0 | 18. 19. |
| 20.00 | Total allowance amount (sum of lines 17-19 fo | or respiratory t | herapy or line | s 17 and 18 | for all others) | 196 977 | |
| | If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than | ı line 2. make n | umns 1-3 for n | hysical ther | any speech nath | alogy or | 20. |
| | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete | ı line 2, make n lines 21-23. | umns 1-3 for p o entries on l | hysical ther ines 21 and | apy, speech path 22 and enter on | alogy or | 20. |
| | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and tra | l line 2, make n lines 21-23. Binees (line 17 | umns 1-3 for p o entries on l | hysical ther ines 21 and | apy, speech path 22 and enter on | alogy or | |
| 21.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3. | n line 2, make n lines 21-23. ainees (line 17 line 9 for all | umns 1-3 for p o entries on l divided by sum others) | hysical ther ines 21 and | apy, speech path 22 and enter on | ology or line 23 | 21. |
| 21.00 22.00 23.00 | the amount from line 20. Otherwise complete weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trained total salary equivalency (see instructions) | line 2, make n lines 21-23. ainees (line 17 line 9 for all ees (line 2 time | umns 1-3 for p o entries on 1 divided by sum others) s line 21) | hysical ther ines 21 and of columns | apy, speech path 22 and enter on 1 and 2, line 9 | ology or line 23 0.00 | 21. |
| 21.00 22.00 23.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance | line 2, make n lines 21-23. ainees (line 17 line 9 for all ees (line 2 time | umns 1-3 for p o entries on 1 divided by sum others) s line 21) | hysical ther ines 21 and of columns | apy, speech path 22 and enter on 1 and 2, line 9 | ology or line 23 | 21. |
| 21.00 22.00 23.00 24.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD TRAVEL ALLOW THE AND AND OPTIONAL TRAVEL ALLOW THE ADDITIONAL TRAVEL | line 2, make n lines 21-23. ainees (line 17 line 9 for all ees (line 2 time | umns 1-3 for p o entries on 1 divided by sum others) s line 21) | hysical ther ines 21 and of columns | apy, speech path 22 and enter on 1 and 2, line 9 | ology or line 23 0.00 | 21.0 22.0 23.0 |
| 21.00 22.00 23.00 24.00 25.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) | n line 2, make n lines 21-23. ainees (line 17 line 9 for all ees (line 2 time | umns 1-3 for po entries on l divided by sum others) s line 21) | hysical ther ines 21 and of columns | apy, speech path 22 and enter on 1 and 2, line 9 | 0.00 0.00 0 196,977 8,669 0 | 21. 22. 23. 24. |
| 21.00 22.00 23.00 24.00 25.00 6.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or | n line 2, make n lines 21-23. ainees (line 17 line 9 for all ees (line 2 time MANCE AND TRAVEL | umns 1-3 for po entries on 1 divided by sum others) is line 21) EXPENSE COMPU | hysical ther ines 21 and of columns TATION - PRO | apy, speech path 22 and enter on 1 and 2, line 9 VIDER SITE | 0.00 0.00 0 196,977 8,669 0 8,669 | 21. 22. 23. 24. 25. 26. |
| 21.00 22.00 23.00 24.00 25.00 26.00 27.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) | n line 2, make n lines 21-23. ainees (line 17 line 9 for all ees (line 2 time WANCE AND TRAVEL sum of lines 24 for respiratory | umns 1-3 for poor entries on 1 divided by sum others) s line 21) EXPENSE COMPU and 25 for al therapy or su | hysical ther ines 21 and of columns TATION - PRO 1 others) m of lines 3 | apy, speech path 22 and enter on 1 and 2, line 9 VIDER SITE | 0.00 0.00 0 196,977 8,669 0 | 21. 22. 23. 24. 25. 26. |
| 22.00 23.00 24.00 55.00 66.00 7.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) | n line 2, make n lines 21-23. ainees (line 17 line 9 for all ees (line 2 time VANCE AND TRAVEL sum of lines 24 for respiratory | umns 1-3 for poor entries on 1 divided by sum others) s line 21) EXPENSE COMPU and 25 for al therapy or su | hysical ther ines 21 and of columns TATION - PRO 1 others) m of lines 3 | apy, speech path 22 and enter on 1 and 2, line 9 VIDER SITE | 0.00 0.00 0 196,977 8,669 0 8,669 | 21. 22. 23. 24. 25. 26. 27. |
| 22.00 23.00 24.00 55.00 66.00 7.00 8.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel | n line 2, make n lines 21-23. ainees (line 17 line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense | umns 1-3 for poetries on 1 divided by sumothers) s line 21) EXPENSE COMPU and 25 for al therapy or su at the provide | hysical ther ines 21 and of columns TATION - PRO 1 others) m of lines 3 | apy, speech path 22 and enter on 1 and 2, line 9 VIDER SITE | 0.00 0.00 0 196,977 8,669 0 8,669 1,397 10,066 | 21. 22. 23. 24. 25. 26. 27. |
| 21.00 22.00 23.00 24.00 5.00 6.00 7.00 8.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of the standard 22) Ine 10 times the sum of t | n line 2, make n lines 21-23. ainees (line 17 line 9 for all ees (line 2 time MANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense | umns 1-3 for poetries on 1 divided by sumothers) s line 21) EXPENSE COMPU and 25 for al therapy or su at the provide | hysical ther ines 21 and of columns TATION - PRO 1 others) m of lines 3 | apy, speech path 22 and enter on 1 and 2, line 9 VIDER SITE | 0.00 0.00 0.96,977 8,669 0.8,669 1,397 10,066 | 21. 22. 23. 24. 25. 26. 27. 28. |
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| 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 1.00 2.00 3.00 3.00 3.00 3.00 3.00 | occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Assistants (line 5 times column 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.00 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) | In line 2, make no lines 21-23. ainees (line 17 line 9 for alloes (line 2 time 3 time 1 times 5 and 2 times 5 and 2 times column 1 times 2 time | umns 1-3 for poentries on l divided by sumothers) s line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUTA 6) 2, line 10) | hysical ther ines 21 and of columns TATION - PRO l others) m of lines 3 r site (sum l others) tory therapy 31) 32) ATION - SERV | apy, speech path 22 and enter on 1 and 2, line 9 VIDER SITE and 4 for all of lines 26 and or sum of | 0.00 0.00 0.00 196,977 8,669 0,8,669 1,397 10,066 1,160 13,617 14,777 0 16,174 0 VIDER SITE 16,417 7,091 23,508 4,169 | 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. |

| OUTSI | MABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS | FURNISHED BY | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 Occupational | 5/30/2013 9:1 | pared: |
|----------------|---|---|--|--|---|--------------------------|------------------|
| | | Combine No. 188 | | · · · · · · · · · · · · · · · · · · · | Therapy | Cost | 1 " |
| 45.00 | (100. • · · · · · · · · · · · · · · · · · · | A control debasedone some control and a control source source | the state and a state of the st | and the state of t | | 1.00 | İ |
| 45.00 46.00 | Optional travel allowance and standard travel Optional travel allowance and optional travel | expense (sum of expense (sum of the control of the | of lines 39 an of lines 42 an Assistants 2.00 | d 42 - see ir d 43 - see ir Aides 3.00 | structions) Trainees | 4,169 0 Total | |
| | PART V - OVERTIME COMPUTATION | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) | 0.00 | 0.00 | 0.0 | 0.00 | 0.00 | 47.00 |
| 18.00 | Overtime rate (see instructions) | 0.00 | 0.00 | 0.0 | 0.00 | | 48.00 |
| | Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT | 0.00 | 0.00 | 0.0 | | | 49.00 |
| | Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) | 0.00 | 0.00 | 0.0 | 0.00 | 0.00 | 50.00 |
| 51.00 | Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE | 0.00 | 0.00 | 0.0 | 0.00 | 0.00 | 51.00 |
| | Adjusted hourly salary equivalency amount (see instructions) | 68.25 | 51.19 | 0.0 | 0.00 | | 52.00 |
| | Overtime cost limitation (line 51 times line 52) | 0 | 0 | | 0 0 | | 53.00 |
| | Maximum overtime cost (enter the lesser of line 49 or line 53) | 0 | 0 | | 0 | | 54.00 |
| | Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52) | 0 | 0 | | 0 | | 55.00 |
| 6.00 | Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for | 0 | o | | 0 | 0 | 56.00 |
| | respiratory therapy and columns 1 through 3 for all others.) | | | | | | |
| | 1 | 1. | , | | | - | |
| | Part VI - COMPUTATION OF THERAPY LIMITATION A | ND EXCESS COST | ADJUSTMENT | THE RESIDENCE OF THE PARTY NAMED IN COLUMN TO | | 1.00 | |
| 7.00 | Salary equivalency amount (from line 23) | | | | | 196,977 | 57.00 |
| 9.00 | Travel allowance and expense - provider site Travel allowance and expense - Offsite servic | (from lines 33, | 34, or 35)) | | | 16,174 | |
| 0.00 | Overtime allowance (from column 5, line 56) | es (iron imes | 44, 45, 05 46 | , | | 4,169 | |
| 1.00 | Equipment cost (see instructions) | | | | | 0 | 60.00 |
| 2.00 | Supplies (see instructions) | | | | | | 62.00 |
| 3.00 | Total allowance (sum of lines 57-62) | | | | | 217,853 | |
| 5.00 | Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION | your records) - if negative, | enter zero) | | | 44,656 | |
| 00.00 | Line 26 = line 24 for respiratory therapy or | sum of lines 74 | and 25 for a | ll others | | 0 660 | 100 00 |
| 00.01 | Line 27 = 11ne 7 times line 3 for respiratory Line 33 = 1ine 28 = sum of lines 26 and 27 LINE 34 CALCULATION | therapy or sum | of lines 3 ar | nd 4 for all | للياء استهاره الماء | 8,669 1,397 10,066 | 100.01 |
| 1.00 | Line 27 = line 7 times line 3 for respiratory | therapy or sum | of lines 3 ar | nd 4 for all | others | 1,397 | 101.00 |
| 01.02 | Line 31 = 11ne 29 for respiratory therapy or : Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION | sum of lines 29 | and 30 for a | ll others | : | 14,777 16,174 | 101.01 |
| 02.00 02.01 | Line 31 = line 29 for respiratory therapy or s Line 32 = line 8 times columns 1 and 2, line 1 13 for all others | sum of lines 29 13 for respirate | and 30 for all ory therapy or | ll others sum of colu | nns 1-3, line | 14,777 0 | 102.00 102.01 |
| 02.02 | Line 35 = sum of lines 31 and 32 | | | | | 14,777 | 102.02 |

| | NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS | FURNISHED BY | Provider | CCN: 151322 | Period: From 01/01/201 To 12/31/201 | Date/Time Pre 5/30/2013 9:1 | pared: |
|---|--|--|--|--|--|---|--|
| * | e de la composition de la composition de la composition de la composition de la composition de la composition La composition de la composition de la composition de la composition de la composition de la composition de la | | <u>.</u> | , | Speech Patholog | 100000000000000000000000000000000000000 | |
| | PART I - GENERAL INFORMATION | | | | e agreement of the state of the state of | 1.00 | |
| 1.00 2.00 3.00 4.00 | Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst | sor or therapist assistant was or | t was on provio on provider sit | te but neithe | e instructions) er supervisor | 52 780 259 0 | 1.00 2.00 3.00 4.00 |
| .00 | Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the instructions) Standard travel expense rate | rvisors or thera apy assistants (| (include only v | visits made b | oy therapy)) (see | 67 0 5.50 | 5.00 6.00 |
| 3.00 | Optional travel expense rate per mile | Supervisors | Therapists | Assistants | Aides | 0.00 Trainees | 7.00 8.00 |
| 00.6 | Total hours worked | 1.00 | 2.00 2,499.00 | 3.00 | 4.00 | 5.00 0 0.00 | 9.00 |
| L1.00 | AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10) | 0.00 29.61 | 59.22 29.61 | 0.0 | 0.0 | | |
| .2.01 .3.00 | Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) | 0 | 12 0 985 | | 0 0 0 | | 12.00 12.01 13.00 |
| 13.01 | Number of miles driven (offsite) | ŏ | 0 | Comment of the second s | o | | 13.01 |
| | Dart TT - CALADY FOUNDAL PAGY | A refer relating magnify for the property of the control of the co | | | | 1.00 | |
| 4.00 | Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1 | , line 10) | | | | 0 | 14.00 |
| L5.00 L6.00 | Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 and 14 and 15 times 14 and 15 times 14 and 15 times 14 and 15 times 14 and 15 times 14 and 15 times 15 t | line 10) line10) | | | | 147,991 0 | 15.00 16.00 |
| | others) | | atory therapy | or lines 14- | ·16 for all | 147,991 | |
| 8.00 9.00 0.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line Total allowance amount (sum of lines 17-19 fo If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete | 10) ine 10) or respiratory t v therapy or col line 2, make n lines 21-23. | therapy or line umns 1-3 for p o entries on l | es 17 and 18 physical ther ines 21 and | for all others) apy, speech pat 22 and enter on | 0 0 147,991 hology or line 23 | 18.0 19.0 |
| 18.00 19.00 20.00 21.00 | others) Aides (column 4, line 9 times column 4, line 1 Trainees (column 5, line 9 times column 5, line 1 times column 5, line 1 times 17-19 for 1 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traine for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine | 10) ine 10) or respiratory to therapy or col line 2, make n lines 21-23. ainees (line 17 | therapy or line umms 1-3 for p o entries on l divided by sum | es 17 and 18 physical ther ines 21 and | for all others) apy, speech pat 22 and enter on | 0 0 147,991 hology or 1 line 23 | 18.00 19.00 20.00 |
| 18.00 19.00 20.00 21.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra | 10) ine 10) or respiratory to therapy or col line 2, make n lines 21-23. tinees (line 17 line 9 for all ees (line 2 time | therapy or line umms 1-3 for p o entries on l divided by sum others) es line 21) | es 17 and 18 shysical ther ines 21 and n of columns | for all others) apy, speech pat 22 and enter on 1 and 2, line 9 | 0 0 147,991 hology or 1 line 23 | 18.00 19.00 20.00 21.00 |
| 18.00 19.00 20.00 21.00 22.00 23.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line 11 times column 5, line 9 times column 5, line 11 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trained to the salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD TRAVEL ALLOW THE AND TRAVEL ALLOW THE AND THE STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD AND OPTIONAL TRAVEL ALLOW THE AND THE STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD AND OPTIONAL TRAVEL AL | 10) ine 10) or respiratory to therapy or col line 2, make n lines 21-23. tinees (line 17 line 9 for all ees (line 2 time | therapy or line umms 1-3 for p o entries on l divided by sum others) es line 21) | es 17 and 18 shysical ther ines 21 and n of columns | for all others) apy, speech pat 22 and enter on 1 and 2, line 9 | 0 0 147,991 hology or 11ne 23 0.00 0 147,991 | 18.00 19.00 20.00 21.00 22.00 23.00 |
| 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line 11 times column 5, line 9 times column 5, line 12 times column 5, line 13 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trainer for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trainer total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) | 10) ine 10) or respiratory to therapy or col line 2, make n lines 21-23. sinees (line 17 line 9 for all les (line 2 time MANCE AND TRAVEL | therapy or line umms 1-3 for p to entries on 1 divided by sum others) is line 21) | es 17 and 18 shysical ther lines 21 and n of columns | for all others) apy, speech pat 22 and enter on 1 and 2, line 9 | 0 0 147,991 hology or 11ne 23 0.00 0 147,991 | 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 |
| 21.00 22.00 23.00 24.00 26.00 27.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line 1 times column 5, line 1 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III – STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD (line 3 times column 2, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) | 10) ine 10) or respiratory to therapy or column 11 the 21-23. lines (line 17 line 9 for alles (line 2 time 18 time 2 time | therapy or line umns 1-3 for p o entries on 1 divided by sum others) es line 21) EXPENSE COMPU | es 17 and 18 chysical ther ines 21 and of columns ITATION - PRO I others) Im of lines 3 | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 VIDER SITE and 4 for all | 0 0 147,991 hology or 1 line 23 0.00 0 147,991 7,669 0 7,669 1,425 | 18.06 19.06 20.06 21.06 22.06 23.06 24.06 25.06 26.06 |
| 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 fo If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel | 10) ine 10) or respiratory to therapy or col line 2, make n lines 21-23. ainees (line 17 line 9 for all les (line 2 time MANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense | therapy or line umns 1-3 for p o entries on 1 divided by sum others) s line 21) EXPENSE COMPU and 25 for al therapy or su at the provide | es 17 and 18 chysical ther ines 21 and of columns ITATION - PRO I others) Im of lines 3 | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 VIDER SITE and 4 for all | 0 0 147,991 hology or 1 line 23 0.00 0 147,991 7,669 0 7,669 1,425 | 18.06 19.06 20.06 21.06 22.06 23.06 24.06 25.06 27.06 |
| 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line 11 times column 5, line 9 times column 5, line 11 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and traine for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of the standard 27) | 10) ine 10) or respiratory to therapy or columns 21-23. inees (line 17 line 9 for alles (line 2 time) ANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense of columns 1 and | therapy or line umns 1-3 for p o entries on 1 divided by sum others) s line 21) EXPENSE COMPU and 25 for al therapy or su at the provide | es 17 and 18 chysical ther ines 21 and of columns ITATION - PRO I others) Im of lines 3 | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 VIDER SITE and 4 for all | 0 0 147,991 hology or 11ne 23 0.00 147,991 7,669 0 7,669 1,425 9,094 | 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 27.00 28.00 |
| 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line 1 times column 5, line 1 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trained to the sum of the sum | 10) ine 10) or respiratory to therapy or colorine 2, make no lines 21-23. tinees (line 17 line 9 for alloes (line 2 time 1 time 1 time 1 time 1 time 1 time 1 time 1 time 1 time 1 time 1 time 1 time 1 time 2 time 2 time 1 time 1 time 1 time 2 time 2 time 1 time 1 time 1 time 2 time 2 time 1 time 1 time 1 time 1 time 1 time 1 time 1 time 2 time 1 time | therapy or line umns 1-3 for p o entries on 1 divided by sum others) es line 21) EXPENSE COMPU and 25 for al therapy or su at the provide | es 17 and 18 chysical ther ines 21 and n of columns ITATION - PRO I others) Im of lines 3 er site (sum | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 VIDER SITE and 4 for all | 0 0 147,991 hology or 11ne 23 0.00 147,991 7,669 0 7,669 1,425 9,094 | 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 27.00 28.00 29.00 30.00 |
| 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 | Aides (Column 4, line 9 times column 4, line Trainees (Column 5, line 9 times column 5, line 1 trainees (Column 5, line 9 times column 5, line 1 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trained for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or standard travel expense (line 7 times line 3 others) Total standard travel allowance and optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) | 10) ine 10) or respiratory to therapy or colline 2, make no lines 21-23. Annees (line 17 line 9 for all les (line 2 times) ANCE AND TRAVEL sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29; 1 and 2, line | therapy or line umns 1-3 for p o entries on 1 divided by sum others) is line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira | es 17 and 18 shysical ther ines 21 and n of columns TATION - PRO I others) Im of lines 3 er site (sum | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 WIDER SITE and 4 for all of lines 26 and | 0 0 147,991 hology or 11ne 23 0.00 147,991 7,669 0,7,669 1,425 9,094 711 0 711 | 18.00 19.00 20.00 21.00 23.00 24.00 25.00 27.00 28.00 30.00 31.00 32.00 |
| 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 7.00 8.00 1.00 2.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line 1 times column 5, line 1 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and traine for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 3, line 10 times column 3, subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel standard travel allowance and standard travel standard travel allowance and standard travel standard travel allowance and standard travel allowance and standard travel | 10) ine 10) or respiratory to therapy or columns 21-23. inees (line 17 line 9 for alles (line 2 time) ANCE AND TRAVEL sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29: 1 and 2, line expense (line expense (line 2) | therapy or line umns 1-3 for p o entries on 1 divided by sum others) es line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira | es 17 and 18 physical ther ines 21 and n of columns TATION - PRO n of lines 3 er site (sum tory therapy | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 WIDER SITE and 4 for all of lines 26 and | 0 0 147,991 hology or 11ne 23 0.00 147,991 7,669 0,7,669 1,425 9,094 711 0 711 0 | 18.00 19.00 20.00 21.00 23.00 24.00 25.00 27.00 28.00 30.00 31.00 33.00 |
| 8.00 9.00 10.00 22.00 33.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 | Aides (Column 4, line 9 times column 4, line Trainees (Column 5, line 9 times column 5, line 1 times (Column 5, line 9 times (Column 5, line 1) times (Column 5, line 1) the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trained for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trained to the salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW (See instructions) line 3 times column 3, line 11) subtotal (line 3 times column 3, line 11) subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) line 3 theres) line 3 theres) line 3 times column 3, line 10 times the sum of Assistants (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWS PART AND OPTIONAL TRA | 10) ine 10) or respiratory to therapy or color line 2, make no lines 21-23. atinees (line 17 line 9 for alloes (line 2 time es (line 2 time es line es es es es es es es es es es es es es | cherapy or line umns 1-3 for p o entries on 1 divided by sum others) es line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and | es 17 and 18 chysical ther ines 21 and n of columns TATION - PRO others) um of lines 3 er site (sum l others) ttory therapy | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 WIDER SITE and 4 for all of lines 26 and or sum of | 0 0 147,991 hology or 11ne 23 0.00 147,991 7,669 0,7,669 1,425 9,094 711 0 711 0 | 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 |
| 18.00 19.00 10.00 11.00 12.00 13.00 14.00 15.00 1.00 1.00 1.00 1.00 1.00 1.00 | others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, lotal allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trainer for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trainer total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Allowance and optional travel (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD TRAVEL ALLOWA STANDARD (line 5 times column 2, line 11) | 10) ine 10) or respiratory to therapy or color line 2, make no lines 21-23. atinees (line 17 line 9 for alloes (line 2 time es (line 2 time es line es es es es es es es es es es es es es | cherapy or line umns 1-3 for p o entries on 1 divided by sum others) es line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and | es 17 and 18 chysical ther ines 21 and n of columns TATION - PRO others) um of lines 3 er site (sum l others) ttory therapy | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 WIDER SITE and 4 for all of lines 26 and or sum of | 0 0 147,991 hology or 11ine 23 0.00 147,991 7,669 0,7,669 1,425 9,094 711 0 711 0 9,094 0 | 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 27.00 28.00 31.00 31.00 32.00 33.00 33.00 |
| 8.00 9.00 10.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 6.00 7.00 | Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l' Total allowance amount (sum of lines 17-19 fust the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trainer for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trainer total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW THE STANDARD AND OPTIONAL TRAVEL ALLOW OPTIONAL TRAVEL ALLOW OPTIONAL TRAVEL ALLOW ASSISTANTS (column 2, line 7 times line 3 others) Total standard travel allowance and optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional Travel expense (line 8 times columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD AND | 10) ine 10) or respiratory to therapy or color line 2, make no lines 21-23. atinees (line 17 line 9 for alloes (line 2 time es (line 2 time es line es es es es es es es es es es es es es | cherapy or line umns 1-3 for p o entries on 1 divided by sum others) es line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and | es 17 and 18 chysical ther ines 21 and n of columns TATION - PRO others) um of lines 3 er site (sum l others) ttory therapy | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 WIDER SITE and 4 for all of lines 26 and or sum of | 0 0 147,991 hology or 11ne 23 0.00 147,991 7,669 0,7,669 1,425 9,094 711 0 711 0 9,094 0 0 | 18.00 19.00 20.00 21.00 23.00 24.00 25.00 27.00 28.00 31.00 32.00 33.00 33.00 34.00 35.00 |
| 1.00 | Aides (Column 4, line 9 times column 4, line Trainees (Column 5, line 9 times column 5, line 1 trainees (Column 5, line 9 times column 5, line 1 allowance amount (sum of lines 17-19 fc If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete weighted average rate excluding aides and trainer for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and trainer total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) subtotal (line 24 for respiratory therapy or standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Allowance Allowance and Optional Travel Expense | to) ine 10) or respiratory to therapy or col line 2, make no lines 21-23. ainees (line 17 line 9 for all les (line 2 time les (line 2 time les (line 2 time les (line 2 time les (line 2 time les (line 2 time les (line 2 time les (line 2 time les (line 2 time les (line 2 time les (line 2 time les (line 2 time les (line 2 time les les line 2 time les line 2 time les line 2 time les line 2 time les line 2 time les line 2 time les line 2 time les line 2 time les line 2 time les line 2 time les line 2 time les line 2 time les line 3 times 2 times les line 3 times 2 times les line 3 times 3 times les lines 5 times 5 times 5 times les lines 5 times 5 times les lines 5 times 5 times les lines 5 times 5 times 5 times les lines 5 times 5 times 5 times 5 times 1 times 5 times 1 times 5 times 1 times | cherapy or line umns 1-3 for p o entries on 1 divided by sum others) s line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT. | es 17 and 18 shysical ther lines 21 and n of columns TATION - PRO l others) um of lines 3 er site (sum l others) story therapy 31) 32) ATION - SERV | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 VIDER SITE and 4 for all of lines 26 and or sum of | 0 0 147,991 hology or 11ne 23 0.00 147,991 7,669 0,7,669 1,425 9,094 711 0 711 0 9,094 0 0 0 0 0 | 18.00 19.00 20.00 21.00 23.00 24.00 25.00 27.00 28.00 31.00 31.00 33.00 35.00 36.00 37.00 38.00 |
| 18.00 19.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 10 | Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line 1 times (column 5, line 9 times column 5, line 1 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traine for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWS Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 3, line 10 times column 3, subtotal (line 29 for respiratory therapy or optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and standard travel approximate travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Therapists (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of lines 36 and 37) | 10) ine 10) or respiratory to therapy or colline 2, make no lines 21-23. Alines (line 17) line 9 for alloes (line 2 time) ANCE AND TRAVEL sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29 11 and 2, line expense (sum of lines 29 12 and 17 line expense (sum of lines 29 13 and 17 line expense (sum of lines 29 14 and 17 line expense (sum of lines 5 and expense (sum of lines 5 and expense 1 times column | cherapy or line umns 1-3 for p o entries on 1 divided by sum others) s line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT. | es 17 and 18 shysical ther lines 21 and n of columns TATION - PRO l others) um of lines 3 er site (sum l others) story therapy 31) 32) ATION - SERV | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 VIDER SITE and 4 for all of lines 26 and or sum of | 0 0 147,991 hology or 11ine 23 0.00 147,991 7,669 0,7,669 1,425 9,094 711 0 711 0 711 0 7111 0 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 7111 0 0 7111 0 0 0 0 | 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 27.00 28.00 31.00 31.00 32.00 33.00 35.00 36.00 37.00 38.00 39.00 |
| 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 8.00 9.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 9.00 9.00 | Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line 1 times column 5, line 9 times column 5, line 1 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traine for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III – STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD TRAVEL ALLOW STANDARD AND OPTIONAL TRAVEL ALLOW STANDARD (line 3 times column 2, line 11) Subtotal (line 24 for respiratory therapy or STANDARD AND OPTIONAL TRAVEL ALLOW OPTIONAL TRAVEL ALLOW OPTIONAL TRAVEL ALLOW OPTIONAL TRAVEL ALLOW OPTIONAL TRAVEL ALLOW ASSISTANTS (column 2, line 7 times line 3 others) Total standard travel allowance and Optional Travel Therapists (column 3, line 10 times the sum of Assistants (column 3, line 10 times columns 1-3, line 13 for all others) Standard travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA STANDARD AND OPTIONAL TRAVEL AL | 10) ine 10) or respiratory to therapy or colline 2, make no lines 21-23. Alines (line 17) line 9 for alloes (line 2 time) ANCE AND TRAVEL sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29 11 and 2, line expense (sum of lines 29 12 and 17 line expense (sum of lines 29 13 and 17 line expense (sum of lines 29 14 and 17 line expense (sum of lines 5 and expense (sum of lines 5 and expense 1 times column | cherapy or line umns 1-3 for p o entries on 1 divided by sum others) s line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT. | es 17 and 18 shysical ther lines 21 and n of columns TATION - PRO l others) um of lines 3 er site (sum l others) story therapy 31) 32) ATION - SERV | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 VIDER SITE and 4 for all of lines 26 and or sum of | 0 0 147,991 hology or 11ne 23 0.00 147,991 7,669 0 7,669 1,425 9,094 711 0 7111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 |
| 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 30.00 44.00 45.00 46.00 47.00 46.00 47.00 46.00 47.00 46.00 47.00 46.00 | Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, line 1 times (column 5, line 9 times column 5, line 1 the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traine for respiratory therapy or columns 1 thru 3, weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWS Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 3, line 10 times column 3, subtotal (line 29 for respiratory therapy or optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and standard travel approximate travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Therapists (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of lines 36 and 37) | to the to the total contract of the series o | cherapy or line umns 1-3 for p o entries on 1 divided by sum others) es line 21) EXPENSE COMPU and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT 6) 2, line 10) | es 17 and 18 shysical ther ines 21 and n of columns TATION - PRO l others) um of lines 3 er site (sum l others) ttory therapy 31) 32) ATION - SERV | for all others) apy, speech pat 22 and enter or 1 and 2, line 9 WIDER SITE and 4 for all of lines 26 and or sum of | 0 0 147,991 hology or 11ne 23 0.00 147,991 7,669 0,7,669 1,425 9,094 711 0 9,094 0 0 0 0VIDER SITE 1,984 0 1,984 369 | 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 27.00 28.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 39.00 40.00 |

| REASONABLE COST DETERMINATION FOR THERAPY SERVICES DUTSIDE SUPPLIERS | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 Parts I-VI Date/Time Pre 5/30/2013 9:1 | pared: | | | |
|--|---|--|---------------------------|---------------------------------------|---|--------|
| Mark the second | | | | Speech Pathology | | 1 |
| | | | | | 1 00 | |
| 6.00 Optional travel allowance and optional trave | expense (sum | of lines 42 an | d 43 - see in | structions) | 1.00 | 46.00 |
| August 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 | Therapists | Assistants | Aides | Trainees | Total | 70.00 |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| PART V - OVERTIME COMPUTATION | | Commission of the commission o | | | en america aparti di Filipano ancia a per | |
| 7.00 Overtime hours worked during reporting | 0.00 | 0.00 | 0.0 | 0.00 | 0.00 | 47.00 |
| period (if column 5, line 47, is zero or | | | | | | |
| equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each | | | | A A A A A A A A A A A A A A A A A A A | | |
| column of line 56) | | | | | | |
| 8.00 Overtime rate (see instructions) | 0.00 | 0.00 | 0.0 | 0.00 | | 48.0 |
| 9.00 Total overtime (including base and overtime | 0.00 | | | 1 | | 49.0 |
| allowance) (multiply line 47 times line 48) | 0.00 | 0.00 | 0.0 | 0.00 | | 73.0 |
| CALCULATION OF LIMIT | | | | | | |
| 0.00 Percentage of overtime hours by category | 0.00 | 0.00 | 0.0 | 0.00 | 0.00 | 50.00 |
| (divide the hours in each column on line 47 | | | | | | |
| by the total overtime worked - column 5, line 47) | | | | | | |
| 1.00 Allocation of provider's standard work year | 0.00 | 0.00 | 0.0 | 0.00 | 0.00 | F1 0 |
| for one full-time employee times the | 0.00 | 0.00 | 0.0 | 0.00 | 0.00 | 51.0 |
| percentages on line 50) (see instructions) | | | | | | |
| DETERMINATION OF OVERTIME ALLOWANCE | | | | | | |
| 2.00 Adjusted hourly salary equivalency amount | 59.22 | 0.00 | 0.0 | 0.00 | | 52.0 |
| (see instructions) | | _ | | | | |
| 3.00 Overtime cost limitation (line 51 times line 52) | 0 | 0 | | 0 | | 53.0 |
| 4.00 Maximum overtime cost (enter the lesser of | n | 0 | | 0 | | F4 0 |
| line 49 or line 53) | V | U | | 0 0 | | 54.0 |
| 5.00 Portion of overtime already included in | 0 | o | | 0 0 | | 55.00 |
| hourly computation at the AHSEA (multiply | | | | | | 33.00 |
| line 47 times line 52) | | | | | | |
| 6.00 Overtime allowance (line 54 minus line 55 - | 0 | 0 | | 0 | 0 | 56.0 |
| if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for | | | | | | |
| respiratory therapy and columns 1 through 3 | | 80 | | | | |
| for all others.) | | | | | | |
| The second secon | | | ****************** | | | |
| The second secon | | | | İ | 1.00 | |
| Part VI - COMPUTATION OF THERAPY LIMITATION A | ND EXCESS COST | ADJUSTMENT | | | | |
| 7.00 Salary equivalency amount (from line 23) | <i>(</i> | | | | 147,991 | |
| 8.00 Travel allowance and expense - provider site 9.00 Travel allowance and expense - Offsite service | (from lines 33 | , 34, or 35)) | | 1 | 9,094 | |
| 0.00 Overtime allowance (from column 5, line 56) | es (Trom lines | 44, 45, or 46 |) | | 2,353 | |
| 1.00 Equipment cost (see instructions) | | | | 1 | 0 | 60.0 |
| 2.00 Supplies (see instructions) | | | | | 262 | |
| 3.00 Total allowance (sum of lines 57-62) | | | | | 2,654 162,354 | |
| 4.00 Total cost of outside supplier services (from | your records) | | | | 4:020 | |
| 5.00 Excess over limitation (line 64 minus line 63 | - if negative | , enter zero) | | | | 65.0 |
| LINE 33 CALCULATION | | | | | | |
| 00.00 Line 26 = line 24 for respiratory therapy or | sum of lines 2 | 4 and 25 for a | ll others | | 7,669 | 100.00 |
| 00.01 Line 27 = line 7 times line 3 for respiratory 00.02 Line 33 = line 28 = sum of lines 26 and 27 | therapy or su | m of lines 3 ar | nd 4 for all | others | 1,425 | |
| LINE 34 CALCULATION | | | | | 9,094 | 100.02 |
| | thorany on cu | m of lines ? a | nd 4 for all | othone | 4 45= | 101 0 |
| 01.00 Line 27 = line 7 times line 3 for respiratory | | ii or rines 5 ar | iu 4 IUF all 1 othore | ochers | 1,425 | |
| 01.00 Line 27 = line 7 times line 3 for respiratory | sum of lines 20 | 9 and 30 for a | | | /11 | 101.01 |
| 01.00 Line 27 = line 7 times line 3 for respiratory 01.01 Line 31 = line 29 for respiratory therapy or | sum of lines 2 | 9 and 30 for a | ochers | | | 101 01 |
| 01.00 Line 27 = line 7 times line 3 for respiratory 01.01 Line 31 = line 29 for respiratory therapy or 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION | sum of lines 2 | 200 | | Ĺ | 2,136 | 101.07 |
| 01.00 Line 27 = line 7 times line 3 for respiratory 01.01 Line 31 = line 29 for respiratory therapy or 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or | sum of lines 2 | 9 and 30 for a | 1 others | <u>.</u> | 2,136 | |
| 01.00 Line 27 = line 7 times line 3 for respiratory 01.01 Line 31 = line 29 for respiratory therapy or 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or 02.01 Line 32 = line 8 times columns 1 and 2, line | sum of lines 2 | 9 and 30 for a | 1 others | mns 1-3. line | 2,136 711 | 102.00 |
| 01.00 Line 27 = line 7 times line 3 for respiratory 01.01 Line 31 = line 29 for respiratory therapy or 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION | sum of lines 2 | 9 and 30 for a | 1 others | mns 1-3, line | 2,136 711 | |

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151322 Period: Worksheet B From 01/01/2012 Part I Date/Time Prepared: 5/30/2013 9:13 am To 12/31/2012 CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE **EMPLOYEE** Subtotal for Cost FIXT EOUIP BENEFITS Allocation (from Wkst A col. 7) 0 1.00 2.00 4.00 4A GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1,190,138 1,190,138 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 93,252 93,252 2.00 4.00 00400 EMPLOYEE BENEFITS 36,496 11,702 917 49,115 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 6,055,490 142,311 11.151 7,335 6,216,287 5.00 7.00 00700 OPERATION OF PLANT 1,455,450 122,547 9,602 1,195 1,588,794 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 95,504 16,596 1,300 113,404 8.00 9.00 00900 HOUSEKEEPING 6,148 425,545 482 840 433,015 9.00 10.00 01000 DIETARY 499,529 79,298 6,213 705 585,745 10.00 01100 CAFETERIA 11.00 90,018 0 90.340 322 11.00 13.00 01300 NURSING ADMINISTRATION 10.785 676,186 845 2,244 690,060 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 445,361 23,539 1,844 713 471,457 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2,567,418 232,774 18,238 6,302 2,824,732 30.00 03100 INTENSIVE CARE UNIT 31.00 314,108 24,213 1,897 1,099 341,317 31.00 43.00 04300 NURSERY 27,687 4,355 341 112 32,495 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 832,762 75,658 5,928 1,818 916,166 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 27,335 8,736 685 111 36,867 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 2,068,236 71,722 5.620 3.492 2,149,070 54.00 60.00 06000 LABORATORY 1,502,469 14,277 1,119 2,541 1,520,406 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 162,524 0 41 162,565 62.00 06500 RESPIRATORY THERAPY 65.00 910,638 30,590 2.397 1,932 945,557 65.00 66.00 06600 PHYSICAL THERAPY 419.884 54,816 4.295 87 479,082 66.00 67.00 06700 OCCUPATIONAL THERAPY 116.092 2,211 173 0 118,476 67.00 68.00 06800 SPEECH PATHOLOGY 148,151 2,211 173 150,535 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 398,838 402,222 2,966 232 186 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 59,768 0 59.768 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,392,669 14,762 1.157 335 2,408,923 73.00 **OUTPATIENT SERVICE COST CENTERS** 90.00 09000 CLINIC 322.802 44,637 3,498 834 371,771 90.00 91.00 09100 EMERGENCY 1.418.019 45,123 3.536 3.301 1,469,979 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1,004,040 77,168 6,046 2,072 1,089,326 95.00 101.00 10100 HOME HEALTH AGENCY 778,278 788,015 101.00 7.927 621 1,189 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPICE

Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPING DIETARY & GENERAL PLANT LINEN SERVICE 5.00 7.00 8.00 9.00 10.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 6,216,287 5.00 7.00 00700 OPERATION OF PLANT 1,979,617 390,823 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 27,896 35,961 177,261 8.00 9.00 00900 HOUSEKEEPING 106,516 13,321 11,927 564,779 9.00 01000 DIETARY 10.00 144,086 171,831 O 50,274 951,936 10.00 11.00 01100 CAFETERIA 22,222 0 0 0 11.00 13.00 01300 NURSING ADMINISTRATION 169,746 23.370 0 6,838 0 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 115,972 51,006 0 14,923 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 694,847 504,392 69.655 147,574 929.875 30.00 31.00 03100 INTENSIVE CARE UNIT 83,960 52,466 2.520 15,351 22,061 31.00 43.00 04300 NURSERY 7,993 9.436 476 2,761 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 225.365 163.943 10,869 47,967 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 9.069 18,930 5,539 0 52.00

Λ

1,127,072

1,190,138

10,030

53,036

O

26,534,687

4,713,782

31,487,055

238,586

0

786

0

4,156

93.252

38,810

10,163

49.115

142

0

88,310

0 116.00

0 200.00

0 201.00

26,456,374 118.00

4,781,137 192.00

31,487,055 202.00

10,816 190.00

238,728 192.01

SUBTOTALS (SUM OF LINES 1-117)

NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

192.00 19200 PHYSICIANS' PRIVATE OFFICES

192.01 19201 MARKETING

200.00

201.00

202.00

| | Markinston | / HOSPITAL Provider | F | reriod: from 01/01/2012 o 12/31/2012 | wof Form CMS-2 Worksheet B Part I Date/Time Prep 5/30/2013 9:13 | pared: |
|--|--|--|---|---|--|---|
| Cost Center Description | ADMINISTRATIVE & GENERAL | PLANT | LAUNDRY & LINEN SERVICE | HOUSEKEEPING | DIETARY | o am |
| 4.00 05400 RADIOLOGY-DIAGNOSTIC | 5.00 528,643 | 7.00 155,413 | 8.00 13,702 | 9.00 45,471 | 10.00 | 54.0 |
| 0.00 06000 LABORATORY | 374,000 | 30,937 | 490 | | 0 | 60.0 |
| 2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 39,989 | 0 | | 0 | 0 | 62.0 |
| 5.00 06500 RESPIRATORY THERAPY 6.00 06600 PHYSICAL THERAPY | 232,595 | 66,284 | | 1 | 0 | 65.0 |
| 7.00 06700 OCCUPATIONAL THERAPY | 117,848 29,144 | 118,780 4,791 | -, | | 0 | |
| 8.00 06800 SPEECH PATHOLOGY | 37,030 | 4,791 | | _, | 0 | 68.0 |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 98,941 | 6,427 | 0 | | o | 71.0 |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENT 3.00 07300 DRUGS CHARGED TO PATIENTS | 14,702 | 31 000 | | 1 -1 | 0 | 72.0 |
| OUTPATIENT SERVICE COST CENTERS | 592,564 | 31,988 | 0 | 9,359 | 0 | 73.0 |
| 0.00 09000 CLINIC | 91,451 | 96,724 | 1,505 | 28,300 | 0 | 90.0 |
| 1.00 09100 EMERGENCY | 361,596 | 97,776 | 58,954 | | 0 | 91.0 |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | . ! . ! | | | | | 92.0 |
| 5.00 09500 AMBULANCE SERVICES | 267,960 | 167,215 | 185 | 40.024 | | 05.0 |
| 01.00 10100 HOME HEALTH AGENCY | 193,841 | 17,177 | 163 | | | 95.0 101.0 |
| SPECIAL PURPOSE COST CENTERS | | KT2 - 1 | | 3,020 | 0 | 101.0 |
| 3.00 11300 INTEREST EXPENSE 6.00 11600 HOSPICE | | | | i | 4 | 113.0 |
| 8.00 SUBTOTALS (SUM OF LINES 1-117) | 4,978,799 | 0 1,842,959 | 177 163 | - | | 116.0 |
| NONREIMBURSABLE COST CENTERS | 1 , 4,570,755 | 1,042,535 | 177,162 | 524,795 | 951,936 | 118.0 |
| 00.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 2,661 | 21,734 | 0 | 6,359 | 0 | 190.0 |
| 02.00 19200 PHYSICIANS' PRIVATE OFFICES 02.01 19201 MARKETING | 1,176,103 | 114,924 | 99 | , | | 192.0 |
| 00.00 Cross Foot Adjustments | 58,724 | 0 | 0 | 0 | | 192.0 |
| 01.00 Negative Cost Centers | 0 | 0 | 0 | 0 | 1. | 200.0 201.0 |
| 2.00 TOTAL (sum lines 118-201) | 6,216,287 | 1,979,617 | 177,261 | • | 951,936 | |
| Cost Center Description | CAFETERIA | NURSING | MEDICAL | Subtotal | Intern & | |
| | | ADMINISTRATION | RECORDS & | ļ | Residents Cost | |
| | | | LIBRARY | | & Post Stepdown | |
| | | | | | Adjustments | |
| GENERAL SERVICE COST CENTERS 00 00100 NEW CAP REL COSTS-BLDG & FIXT | 1 | 13.00 | 16.00 | 24.00 | 25.00 | |
| .00 00200 NEW CAP REL COSTS-MVBLE FOLITP | | | | | | 1.00 |
| 00 00400 EMPLOYEE BENEFITS | | | , | | | 2.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL | | | | | | 2.0 4.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT | 2000 | | | | | 2.0 4.0 5.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE | | | | | | 2.0 4.0 5.0 7.0 8.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01000 DIETARY | The state of the s | | | | | 2.0 4.0 5.0 7.0 8.0 9.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01100 CAFETERIA | 112,562 | | | | | 2.0 4.0 5.0 7.0 8.0 9.0 10.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEPING 0.00 01000 DIETARY 00 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION | 7,360 | 897,374 | | | | 2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01000 DIETARY 0.00 0100 CAFETERIA 0.00 01300 NURSING ADMINISTRATION 0.00 01600 MEDICAL RECORDS & LIBRARY | | 897,374 0 | 657,763 | | | 2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01000 DIETARY00 01100 CAFETERIA 0.00 01300 NURSING ADMINISTRATION 0.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS | 7,360 4,405 | 0 | | 5 811 846 | - And a second s | 2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 16.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01000 DIETARY 0.00 01100 CAFETERIA 0.00 01300 NURSING ADMINISTRATION 0.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03100 INTENSIVE CARE UNIT | 7,360 | | 657,763 120,912 0 | 5,811,846 587,017 | 0 | 2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 16.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01000 DIETARY 0.00 01100 CAFETERIA 0.00 01300 NURSING ADMINISTRATION 0.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03100 INTENSIVE CARE UNIT 0.00 04300 NURSERY | 7,360 4,405 33,161 | 0 486,698 | 120,912 | 5,811,846 587,017 60,834 | 0 | 2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 30.0 31.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING .00 01000 DIETARY .00 01100 CAFETERIA .00 01300 NURSING ADMINISTRATION .00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS .00 03100 INTENSIVE CARE UNIT .00 04300 NURSERY ANCILLARY SERVICE COST CENTERS | 7,360 4,405 33,161 4,423 489 | 0 486,698 64,919 7,184 | 120,912 0 0 | 587,017 60,834 | 0 0 0 | 2.0 4.0 5.0 7.0 8.0 9.0 11.0 13.0 16.0 30.0 43.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING .00 01000 DIETARY .00 01100 CAFETERIA .00 01300 NURSING ADMINISTRATION .00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS .00 03000 ADULTS & PEDIATRICS .00 03100 INTENSIVE CARE UNIT .00 04300 NURSERY ANCILLARY SERVICE COST CENTERS .00 05000 OPERATING ROOM .00 05200 DELIVERY ROOM & LABOR ROOM | 7,360 4,405 33,161 4,423 489 4,832 | 0 486,698 64,919 7,184 70,928 | 120,912 0 0 | 587,017 60,834 1,440,070 | 0 0 0 | 2.0 4.0 5.0 7.0 8.0 9.0 11.0 13.0 16.0 30.0 43.0 50.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01000 DIETARY 0.00 01100 CAFETERIA 0.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 0.00 03100 INTENSIVE CARE UNIT 0.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 0.00 05000 OPERATING ROOM 0.00 05200 DELIVERY ROOM & LABOR ROOM 0.00 05400 RADIOLOGY-DIAGNOSTIC | 7,360 4,405 33,161 4,423 489 | 0 486,698 64,919 7,184 | 120,912 0 0 | 587,017 60,834 1,440,070 77,800 | 0 0 0 | 2.0 4.0 5.0 7.0 8.0 9.0 11.0 13.0 16.0 30.0 43.0 50.0 52.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING .00 01000 DIETARY .00 01100 CAFETERIA .00 01300 NURSING ADMINISTRATION .00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS .00 03100 INTENSIVE CARE UNIT .00 04300 NURSERY ANCILLARY SERVICE COST CENTERS .00 05000 OPERATING ROOM .00 05400 RADIOLOGY-DIAGNOSTIC .00 06000 LABORATORY | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 | 0 486,698 64,919 7,184 70,928 6,923 0 | 120,912 0 0 | 587,017 60,834 1,440,070 | 0 0 0 | 2.0 4.0 5.0 7.0 8.0 9.0 11.0 13.0 16.0 30.0 43.0 50.0 52.0 54.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 00 01000 DIETARY 00 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION 00 01300 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05400 RADIOLOGY-DIAGNOSTIC 00 06000 LABORATORY 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 | 0 486,698 64,919 7,184 70,928 6,923 0 0 | 120,912 0 0 0 169,278 166,859 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 | 0 0 0 0 0 | 2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 16.0 50.0 52.0 60.0 62.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 00 01000 DIETARY 00 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05400 RADIOLOGY-DIAGNOSTIC 00 06000 LABORATORY 00 06500 WHOLE BLOOD & PACKED RED BLOOD CELLS 00 06500 RESPIRATORY THERAPY | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 | 0 486,698 64,919 7,184 70,928 6,923 0 0 | 120,912 0 0 0 169,278 166,859 0 38,692 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 | 0 0 0 0 0 | 2.00 4.00 7.00 8.00 9.00 11.00 16.00 30.00 31.00 43.00 552.00 652.00 662.00 665.00 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 00 01000 DIETARY .00 01100 CAFETERIA .00 01300 NURSING ADMINISTRATION .00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS .00 03000 ADULTS & PEDIATRICS .00 03100 INTENSIVE CARE UNIT .00 04300 NURSERY ANCILLARY SERVICE COST CENTERS .00 05000 OPERATING ROOM .00 05200 DELIVERY ROOM & LABOR ROOM .00 05400 RADIOLOGY-DIAGNOSTIC .00 06000 LABORATORY .00 06500 RESPIRATORY THERAPY .00 06600 PHYSICAL THERAPY .00 06700 OCCUPATIONAL THERAPY | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 | 0 486,698 64,919 7,184 70,928 6,923 0 0 | 120,912 0 0 0 169,278 166,859 0 38,692 29,019 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 | 0 0 0 0 0 | 2.00 4.00 7.00 8.00 9.00 11.00 13.00 31.00 31.00 43.00 52.00 552.00 662.00 665.00 666.00 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 00 01000 DIETARY .00 01100 CAFETERIA .00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS .00 03000 ADULTS & PEDIATRICS .00 03100 INTENSIVE CARE UNIT .00 04300 NURSERY ANCILLARY SERVICE COST CENTERS .00 05000 OPERATING ROOM .00 05200 DELIVERY ROOM & LABOR ROOM .00 05200 DELIVERY ROOM & LABOR ROOM .00 05400 RADIOLOGY-DIAGNOSTIC .00 06000 LABORATORY .00 06500 RESPIRATORY THERAPY .00 06600 PHYSICAL THERAPY .00 06700 OCCUPATIONAL THERAPY .00 06700 OCCUPATIONAL THERAPY .00 06800 SPEECH PATHOLOGY | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 | 120,912 0 0 0 169,278 166,859 0 38,692 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 | 0 0 0 0 0 0 | 2.0 4.0 7.0 8.0 9.0 11.0 13.0 16.0 30.0 31.0 43.0 50.0 60.0 62.0 62.0 66.0 67.0 67.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 00 01000 DIETARY 00 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 00 03100 INTENSIVE CARE UNIT 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05400 RADIOLOGY-DIAGNOSTIC 00 06000 LABORATORY 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 00 06500 RESPIRATORY THERAPY 00 06600 PHYSICAL THERAPY 00 06600 SPEECH PATHOLOGY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 0 748 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 | 120,912 0 0 0 169,278 166,859 0 38,692 29,019 0 14,509 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 | 0 | 2.0 4.0 7.0 8.0 9.0 11.0 13.0 11.0 30.0 31.0 43.0 50.0 60.0 62.0 65.0 66.0 66.0 66.0 66.0 66.0 66.0 66 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 00 01000 DIETARY 00 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05400 RADIOLOGY-DIAGNOSTIC 00 06000 LABORATORY 00 06500 RESPIRATORY THERAPY 00 06500 RESPIRATORY THERAPY 00 06500 SPEECH PATHOLOGY 00 06800 SPEECH PATHOLOGY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 07200 IMPL. DEV. CHARGED TO PATIENTS | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 0 748 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 0 | 120,912 0 0 0 169,278 166,859 0 38,692 29,019 0 14,509 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 74,470 | 0 | 2.00 4.00 7.00 8.00 9.00 11.00 13.00 13.00 30.00 31.00 43.00 52.00 65.00 66.00 66.00 66.00 66.00 67.00 71.00 72.00 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 00 01000 DIETARY .00 01100 CAFETERIA .00 01300 NURSING ADMINISTRATION .00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS .00 03000 ADULTS & PEDIATRICS .00 03100 INTENSIVE CARE UNIT .00 04300 NURSERY ANCILLARY SERVICE COST CENTERS .00 05000 OPERATING ROOM .00 05200 DELIVERY ROOM & LABOR ROOM .00 05400 RADIOLOGY-DIAGNOSTIC .00 06000 LABORATORY .00 06500 WHOLE BLOOD & PACKED RED BLOOD CELLS .00 06600 PHYSICAL THERAPY .00 06600 PHYSICAL THERAPY .00 06600 SPEECH PATHOLOGY .00 07300 DRUGS CHARGED TO PATIENTS .00 07300 DRUGS CHARGED TO PATIENTS .00 07300 DRUGS CHARGED TO PATIENTS .00 07300 DRUGS CHARGED TO PATIENTS .00 0740TIENT SERVICE COST CENTERS .00 07400 DRUGS CHARGED TO PATIENTS .00 0774TIENT SERVICE COST CENTERS | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 0 748 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 | 120,912 0 0 0 169,278 166,859 0 38,692 29,019 0 14,509 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 | 0 | 2.00 4.00 7.00 8.00 9.00 11.00 13.00 13.00 30.00 31.00 43.00 52.00 65.00 66.00 66.00 66.00 66.00 67.00 71.00 72.00 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 00 01000 DIETARY 00 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05400 RADIOLOGY-DIAGNOSTIC 00 06500 RESPIRATORY THERAPY 00 06500 RESPIRATORY THERAPY 00 06600 PHYSICAL THERAPY 00 06600 PHYSICAL THERAPY 00 06700 OCCUPATIONAL THERAPY 00 06800 SPEECH PATHOLOGY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 07200 IMPL DEV. CHARGED TO PATIENTS 00 07300 DRUGS CHARGED TO PATIENTS 00 07900 CLINIC | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 0 748 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 0 | 120,912 0 0 0 169,278 166,859 0 38,692 29,019 0 14,509 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 74,470 3,045,166 | 0 0 0 0 0 0 0 0 | 2.0 4.0 7.0 8.0 9.0 11.0 13.0 16.0 30.0 31.0 43.0 60.0 62.0 66.0 67.0 68.0 67.0 72.0 72.0 73.0 73.0 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 00 01000 DIETARY00 01100 CAFETERIA00 01300 NURSING ADMINISTRATION00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS00 03100 INTENSIVE CARE UNIT00 04300 NURSERY ANCILLARY SERVICE COST CENTERS00 05000 OPERATING ROOM00 05400 RADIOLOGY-DIAGNOSTIC00 05400 RADIOLOGY-DIAGNOSTIC00 06500 RESPIRATORY THERAPY00 06600 PHYSICAL THERAPY00 06600 PHYSICAL THERAPY00 06600 SPEECH PATHOLOGY00 06700 OCCUPATIONAL THERAPY00 06700 MEDICAL SUPPLIES CHARGED TO PATIENTS00 07200 IMPL. DEV. CHARGED TO PATIENTS00 07200 IMPL. DEV. CHARGED TO PATIENTS00 07200 OUTPATIENT SERVICE COST CENTERS00 09000 CLINIC | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 0 748 0 2,332 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 0 | 120,912 0 0 0 169,278 166,859 0 38,692 29,019 0 14,509 0 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 74,470 | 0 0 0 0 0 0 0 0 0 | 2.0 4.0 7.0 9.0 10.0 11.0 13.0 16.0 30.0 31.0 43.0 50.0 60.0 62.0 66.0 66.0 66.0 67.0 68.0 72.0 72.0 73.0 90.0 |
| 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 01000 OLOUD DIETARY 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05400 RADIOLOGY-DIAGNOSTIC 00 06500 LABORATORY 00 06500 WHOLE BLOOD & PACKED RED BLOOD CELLS 00 06500 RESPIRATORY THERAPY 00 06600 PHYSICAL THERAPY 00 06600 PHYSICAL THERAPY 00 06600 SPEECH PATHOLOGY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 07200 IMPL DEV. CHARGED TO PATIENTS 00 07300 DRUGS CHARGED TO PATIENTS 00 07400 CLINIC 00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 0 748 0 2,332 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 0 0 | 120,912 0 0 0 169,278 166,859 0 38,692 29,019 0 14,509 0 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 74,470 3,045,166 | 0 0 0 0 0 0 0 0 0 | 2.0 4.0 7.0 8.0 9.0 11.0 11.0 11.0 11.0 11.0 11.0 11. |
| 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01000 DIETARY 0.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 0.00 03100 INTENSIVE CARE UNIT 0.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 0.00 05200 DELIVERY ROOM & LABOR ROOM 0.00 05200 DELIVERY ROOM & LABOR ROOM 0.00 05400 RADIOLOGY-DIAGNOSTIC 0.00 06500 RESPIRATORY 0.00 06500 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.00 06600 PHYSICAL THERAPY 0.00 06600 PHYSICAL THERAPY 0.00 06600 PHYSICAL THERAPY 0.00 06600 SPEECH PATHOLOGY 0.00 07300 DRUGS CHARGED TO PATIENTS 0.00 07300 DRUGS CHARGED TO PATIENTS 0.00 07300 DRUGS CHARGED TO PATIENTS 0.00 07400 MERGENCY 0.00 09000 CLINIC 0.00 09500 AMBULANCE SERVICES 0.00 09500 AMBULANCE SERVICES | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 748 0 2,332 4,245 13,518 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 0 0 0 0 62,307 198,415 | 120,912 0 0 0 169,278 166,859 0 38,692 29,019 0 14,509 0 26,601 91,893 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 74,470 3,045,166 682,904 2,320,738 | 0 | 2.00 4.00 5.00 9.00 11.00 13.00 13.00 43.00 50.00 60.00 66.00 66.00 66.00 66.00 67.00 68.00 772.00 772.00 773.00 |
| 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01000 DIETARY 0.00 01000 DIETARY 0.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 0.00 03100 INTENSIVE CARE UNIT 0.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 0.00 05000 OPERATING ROOM 0.00 05200 DELIVERY ROOM & LABOR ROOM 0.00 05400 RADIOLOGY-DIAGNOSTIC 0.00 06500 RESPIRATORY 0.00 06500 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.00 06600 PHYSICAL THERAPY 0.00 06600 PHYSICAL THERAPY 0.00 06600 PHYSICAL THERAPY 0.00 06600 SPEECH PATHOLOGY 0.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.00 07300 DRUGS CHARGED TO PATIENTS 0.00 07300 DRUGS CHARGED TO PATIENTS 0.00 07300 DRUGS CHARGED TO PATIENTS 0.00 09200 UNDERSENVICE COST CENTERS 0.00 09500 AMBULANCE SERVICES 0.00 09500 AMBULANCE SERVICES 0.00 09500 AMBULANCE SERVICES 0.00 10100 HOME HEALTH AGENCY | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 0 748 0 2,332 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 0 0 | 120,912 0 0 169,278 166,859 0 38,692 29,019 0 14,509 0 26,601 91,893 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 74,470 3,045,166 682,904 2,320,738 | 0 0 0 0 0 0 0 0 0 0 0 0 | 2.00 4.00 7.00 9.00 11.00 13.00 13.00 31.00 43.00 50.00 55.00 66.00 66.00 66.00 67.00 68.00 77.00 90.00 99.00 99.00 99.00 |
| 00 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 01000 OITETARY 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 00 03100 INTENSIVE CARE UNIT 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05400 RADIOLOGY-DIAGNOSTIC 00 06000 LABORATORY 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 00 06500 RESPIRATORY THERAPY 00 06600 PHYSICAL THERAPY 00 06600 PHYSICAL THERAPY 00 06700 OCCUPATIONAL THERAPY 00 06700 OCCUPATIONAL THERAPY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 07200 IMPL. DEV. CHARGED TO PATIENTS 00 07200 IMPL. DEV. CHARGED TO PATIENTS 00 07200 IMPL. DEV. CHARGED TO PATIENTS 00 07200 IMPL. DEV. CHARGED TO PATIENTS 00 07900 CLINIC 00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 1.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 0 748 0 2,332 4,245 13,518 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 0 0 0 0 62,307 198,415 | 120,912 0 0 0 169,278 166,859 0 38,692 29,019 0 14,509 0 26,601 91,893 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 74,470 3,045,166 682,904 2,320,738 | 0 0 0 0 0 0 0 0 0 0 0 0 | 2.00 4.00 5.00 7.00 8.00 9.00 11.00 13.00 13.00 43.00 55.00 65.00 66.00 66.00 67.00 66.00 67.20 67.20 90.00 91.00 92.00 |
| 00400 EMPLOYEE BENEFITS 00 00500 ADMINISTRATIVE & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING 0.00 01000 DIETARY 0.00 01000 DIETARY 0.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 0.00 03100 INTENSIVE CARE UNIT 0.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 0.00 05000 OPERATING ROOM 0.00 05200 DELIVERY ROOM & LABOR ROOM 0.00 05400 RADIOLOGY-DIAGNOSTIC 0.00 06500 RESPIRATORY 0.00 06500 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.00 06600 PHYSICAL THERAPY 0.00 06600 PHYSICAL THERAPY 0.00 06600 PHYSICAL THERAPY 0.00 06600 SPEECH PATHOLOGY 0.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.00 07300 DRUGS CHARGED TO PATIENTS 0.00 07300 DRUGS CHARGED TO PATIENTS 0.00 07300 DRUGS CHARGED TO PATIENTS 0.00 09200 UNDERSENVICE COST CENTERS 0.00 09500 AMBULANCE SERVICES 0.00 09500 AMBULANCE SERVICES 0.00 09500 AMBULANCE SERVICES 0.00 10100 HOME HEALTH AGENCY | 7,360 4,405 33,161 4,423 489 4,832 472 14,159 13,082 187 8,312 837 0 0 748 0 2,332 4,245 13,518 | 0 486,698 64,919 7,184 70,928 6,923 0 0 0 0 0 0 0 0 62,307 198,415 | 120,912 0 0 169,278 166,859 0 38,692 29,019 0 14,509 0 26,601 91,893 | 587,017 60,834 1,440,070 77,800 3,075,736 2,114,825 202,741 1,313,864 784,167 153,813 208,267 510,218 74,470 3,045,166 682,904 2,320,738 | 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2.00 4.00 5.00 9.00 11.00 13.00 13.00 43.00 50.00 60.00 66.00 66.00 66.00 66.00 67.00 68.00 772.00 772.00 773.00 |

| COST ALLOCATION - GENERAL SERVICE COSTS | | PERRY COUNT | | CCN: 151322 | Period: | u of Form CMS- | -4552- |
|---|---|--------------------------------|---------------------------------------|--|----------------------------------|--|--------------------------------------|
| entre de la companya de la companya de la companya de la companya de la companya de la companya de la companya | | | TTOVIGET | CCI4. 131322 | From 01/01/2012 To 12/31/2012 | | |
| | Cost Center Description | CAFETERIA | NURSING ADMINISTRATION | MEDICAL RECORDS & LIBRARY | Subtotal | 5/30/2013 9: Intern & Residents Cost & Post Stepdown | T |
| MONI | DETAINING AND F. COOR SETS OF THE PROPERTY OF | 11.00 | 13.00 | 16.00 | 24.00 | Adjustments 25.00 | |
| 190.00 190 | REIMBURSABLE COST CENTERS 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN | opione and an area | part to the second control of the | ************************************** | | a comment of | |
| 192 00 192 | 00 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | | 0 41,570 | C | 190.0 |
| 192 01 192 | 01 MARKETING | 0 | 1 | | 0 6,105,888 | | 192. |
| 200.00 | Cross Foot Adjustments | 0 | 0 | | 0 297,452 | | 192.0 |
| 201.00 | Negative Cost Centers | | | | 0 | 0 | 200.0 |
| 202.00 | TOTAL (sum lines 118-201) | 112 503 | 0 | | 0 | 0 | 201.0 |
| | Cost Center Description | 112,562 Total 26.00 | 897,374 | 657,76 | 31,487,055 | . 0 | 202.0 |
| GENE | ERAL SERVICE COST CENTERS | 20.00 | L | | | | |
| L.00 0010 | OO NEW CAP REL COSTS-BLDG & FTXT | 1 | | | | | 1 |
| .00 0020 | 00 NEW CAP REL COSTS-MVRLE FORTP | | | | | | 1.0 |
| 1.00 0040 | OO EMPLOYEE BENEFITS | | | | | | 2.0 |
| .00 0050 | 00 ADMINISTRATIVE & GENERAL | | | | | | 4.0 |
| ′.00 007(| OO OPERATION OF PLANT | | | | | | 5.0 |
| .00 0080 | 00 LAUNDRY & LINEN SERVICE | | | | | | 7.0 |
| | 00 HOUSEKEEPING | | | | | | 8.0 |
| | 00 DIETARY | | | | | | 9.0 |
| 1.00 0110 | OO CAFETERIA | | | | | | 11.0 |
| 00 0160 | OU NURSING ADMINISTRATION | | | | | | 13.0 |
| TNDA | 00 MEDICAL RECORDS & LIBRARY |] | | | | | 16.0 |
| 7 00 0300 | TIENT ROUTINE SERVICE COST CENTERS O ADULTS & PEDIATRICS | 1 | | | | ere e e e e e e e e e e e e e e e e e e | 10.0 |
| 1.00 0310 | 0 INTENSIVE CARE UNIT | 5,811,846 | | | | | 30.0 |
| 3.00 0430 | 00 NURSERY | 587,017 | | | | | 31.0 |
| | LLARY SERVICE COST CENTERS | 60,834 | | | | | 43.0 |
| 0.00 0500 | O OPERATING ROOM | 1 440 070 | · · · · · · · · · · · · · · · · · · · | | | | |
| 2.00 0520 | O DELIVERY ROOM & LABOR ROOM | 1,440,070 | | | | | 50.0 |
| 4.00 0540 | 0 RADIOLOGY-DIAGNOSTIC | 77,800 3,075,736 | | | | | 52.0 |
| 0.00 0600 | 0 LABORATORY | 2,114,825 | | | | | 54.0 |
| 2.00 0620 | WHOLE BLOOD & PACKED RED BLOOD CELLS | 202,741 | | | | | 60.0 |
| 5.00 ∃0650 | U RESPIRATORY THERAPY | 1,313,864 | | | | | 62.0 |
| 5.00 0660 | 0 PHYSICAL THERAPY | 784,167 | | | | | 65.0 |
| 7.00 0670 | O OCCUPATIONAL THERAPY | 153,813 | | | | Į | 66.0 |
| 0680 | O SPEECH PATHOLOGY | 208,267 | | | | | 67.0 |
| 1.00 0710 | O MEDICAL SUPPLIES CHARGED TO PATIENTS | 510,218 | | | | | 68.0 |
| 2.00 0720 | O IMPL. DEV. CHARGED TO PATIENT | 74,470 | | | | | 71.0 |
| O O O O | D DRUGS CHARGED TO PATIENTS ATIENT SERVICE COST CENTERS | 3,045,166 | | | | | 73.0 |
| 0900 | DICITATE | | | | | | 73.00 |
| 00 0910 | D EMERGENCY | 682,904 | | | | | 90.00 |
| 2.00 0920 | OBSERVATION BEDS (NON-DISTINCT PART) | 2,320,738 | | | | | 91.00 |
| OTHER | REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 09500 | AMBULANCE SERVICES | 1 572 610 | | | | | |
| | HOME HEALTH AGENCY | 1,573,610 1,004,059 | | | | | 95.00 |
| 1.00 10100 | AL PURPOSE COST CENTERS | +,004,009 | 1 10 100 1 | | | | 101.00 |
| 1.00 10100 SPECI | _ a company of the c | | | | | | |
| 01.00 10100 SPECI 3.00 11300 | INTEREST EXPENSE | | | | | į: | 113.00 |
| 3.00 10100 SPECI 3.00 11300 6.00 11600 | HOSPICE | n | | | | | |
| SPECI 3.00 11300 6.00 11600 8.00 | HOSPICE SUBTOTALS (SUM OF LINES 1-117) | 0 25,042,145 | | | | | |
| 3.00 10100 SPECI 3.00 11300 6.00 11600 8.00 | HOSPICE SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS | 0 25,042,145 | | | | | |
| 11.00 10100 SPECI 3.00 11300 6.00 11600 8.00 NONRE 0.00 19000 | HOSPICE SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 25,042,145 41,570 | | | | | 118.00 |
| 3.00 10100 SPECI 3.00 11300 6.00 11600 8.00 NONRE 0.00 19000 2.00 19200 | HOSPICE SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES | | | | | 1 | 118.00 190.00 |
| 01.00 10100 SPECI 3.00 11300 6.00 11600 8.00 NONRE 10.00 19000 12.00 19200 12.01 19201 | HOSPICE SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES MARKETING | 41,570 | | | | 1 | 118.00 190.00 192.00 |
| 01.00 10100 SPECI 13.00 11300 16.00 11600 18.00 NONRE 10.00 19000 12.00 19200 12.01 19201 10.00 | HOSPICE SUBTOTALS (SUM OF LINES 1-117) SIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES MARKETING Cross Foot Adjustments | 41,570 6,105,888 | | | | 1 | 116.00 118.00 190.00 192.00 |
| 01.00 10100 SPECI 13.00 11300 16.00 11600 18.00 NONRE 10.00 19000 12.00 19200 12.01 19201 | HOSPICE SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES MARKETING | 41,570 6,105,888 297,452 | | | |]]] | 118.00 190.00 192.00 |

0

1.190.138

93.252

0 201.00

12,619 202.00

0

1,283,390

90.1

91.

7

19

20:

202.00

TOTAL (sum lines 118-201)

| | Financial Systems | PERRY COUNT | Y HOSPITAL | | In Lie | eu of Form CMS- | 2552-1 |
|---------|--|-----------------|---------------------------|---------------------------------------|---|--|--------|
| ALLOCA | ATION OF CAPITAL RELATED COSTS | | | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II | pared: |
| | Cost Center Description | CAFETERIA | NURSING ADMINISTRATION | MEDICAL RECORDS & LIBRARY | Subtotal | Intern & Residents Cost & Post Stepdown | |
| | parameter and the second secon | 11.00 | 13.00 | 16.00 | 24.00 | Adjustments 25.00 | - |
| | GENERAL SERVICE COST CENTERS | 1 | | | 24.00 | 23.00 | 20.00 |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | T 1 | e e e e e e e e e e e e e e e e e e e | 1 | Print a commence of the contract of the contra | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS | | | | | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPING | | | | | , | 4 |
| | 01000 DIETARY | | | | | | 9.00 |
| 11.00 | 01100 CAFETERIA | 638 | | | | | 10.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | 42 | 1 | | | | 11.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 25 | | 32,46 | 7 | | 13.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 2,3 | · | 32,40 | 4 | | 16.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 188 | 9,932 | F 06 | 424.000 | | |
| 31.00 | 03100 INTENSIVE CARE UNIT | 25 | | 5,96 | | | |
| 43.00 | 04300 NURSERY | | | | 0 36,613 | | 1 |
| | ANCILLARY SERVICE COST CENTERS | 3 | 147 | | 0 5,868 | 0 | 43.00 |
| 50.00 | 05000 OPERATING ROOM | 27 | 1 1 1 1 1 1 | | al' ' | | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 3 | _, | | 0 103,246 | | |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | 1 | | | 0 11,297 | - | |
| 60.00 | 06000 LABORATORY | 80 | 1 1 | 8,35 | | 0 | |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 74 | 1 -1 | 8,23 | , - | 0 | 60.00 |
| 65 00 | 06500 RESPIRATORY THERAPY | 1 | | | 1,010 | 0 | 62.00 |
| 66 00 | 06600 PHYSICAL THERAPY | 47 | | 1,91 | | | 65.00 |
| 67 00 | 06700 OCCUPATIONAL THERAPY | 5 | 1 | 1,43 | , , , , , | | 66.00 |
| 68 00 | 06800 SPEECH PATHOLOGY | 0 | 1 | | 0 3,486 | 0 | 67.00 |
| 71 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 71 | , , , , , , , , | 0 | 68.00 |
| 72 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 4 | 0 | ! | 0 6,224 | 0 | 71.00 |
| 72.00 | 07200 DOUGE GUARGED TO PATIENT | 0 | 0 | • | 0 367 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 13 | 0 | | 0 33,321 | 0 | 73.00 |
| 00.00 | OUTPATIENT SERVICE COST CENTERS 09000 CLINIC | processor and a | | | | | |
| | 09100 CLINIC 09100 EMERGENCY | 24 | -, | 1,31 | 60,968 | 0 | 90.00 |
| 92.00 | 00200 PREFRIENCY | 77 | 4,049 | 4,53 | 81,876 | 0 | 91.00 |
| 32.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | 0 | 92.00 |
| 05.00 | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101 00 | 09500 AMBULANCE SERVICES | 0 | | (| 103,507 | 0 | 95.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | | 15,038 | | 101.00 |
| 112 00 | SPECIAL PURPOSE COST CENTERS | | | | | • | |
| 112.00 | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 116.00 | 11600 HOSPICE | 0 | 0 | (| 0 | : | 116.00 |
| | Com C. Cines I III) | 638 | 18,313 | 32,467 | 7 1,171,129 | | 118.00 |
| 100.00 | NONREIMBURSABLE COST CENTERS | | , | | | J. | |
| TAO '00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | (| 12,577 | n | 190.00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | ò | | | 192.00 |
| | 19201 MARKETING | 0 | ō | à | 1,504 | 1 | 192.00 |
| 200.00 | Cross Foot Adjustments | - | | ` | 0 | 1 | 200.00 |
| | Negative Cost Centers | 0 | 0 | , | , 0 | | |
| 201.00 | TOTAL (sum lines 118-201) | U | U | ι | J) 11) | n: | 201.00 |

| ALLOCA | TION OF CAPITAL RELATED COSTS | | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time P 5/30/2013 9 | repared: |
|--------|--|---------------------------|--|--|--|-----------|
| | Cost Center Description | Total 26.00 | nganakania inggaga | | ; 3/ 30/ 2013 9 | . T.) all |
| | GENERAL SERVICE COST CENTERS | | P. M. L. Marcello, Mr. L. Land, L. Karre, Ph. Lang. L. & C. L. C. L. Languages | Contract to the contract of th | the control of the second of | |
| | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | 1.0 |
| | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | 2.0 |
| | 00400 EMPLOYEE BENEFITS | | | | • | 4.0 |
| | 00500 ADMINISTRATIVE & GENERAL | | | | | 5.0 |
| | 00700 OPERATION OF PLANT | | | | | 7.0 |
| | 00800 LAUNDRY & LINEN SERVICE | | | | | 8.0 |
| | 00900 HOUSEKEEPING | | | | | 9.0 |
| | 01000 DIETARY | | | | | 10.0 |
| | 01100 CAFETERIA | | | | | 11.0 |
| | 01300 NURSING ADMINISTRATION | | | | | 13.0 |
| L6.00 | 01600 MEDICAL RECORDS & LIBRARY | | | | | 16.0 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| | 03000 ADULTS & PEDIATRICS | 434,062 | | | | 30.0 |
| | 03100 INTENSIVE CARE UNIT | 36,613 | | | | 31.0 |
| | 04300 NURSERY | 5,868 | | | | 43.0 |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 0.00 | 05000 OPERATING ROOM | 103,246 | The state of the s | ANTE CALL AND CALL AND CALL AND CALL | | 50.0 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 11,297 | | | | 52.0 |
| | 05400 RADIOLOGY-DIAGNOSTIC | 113,644 | | | | 54.0 |
| 0.00 | 06000 LABORATORY | 36,178 | | | | 60.0 |
| 2.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 1,010 | | | | 62.0 |
| 5.00 | 06500 RESPIRATORY THERAPY | 46,784 | | | | 65.0 |
| 6.00 | 06600 PHYSICAL THERAPY | 73,241 | | | | 66.0 |
| 7.00 | 06700 OCCUPATIONAL THERAPY | 3,486 | | | | 67.0 |
| | 06800 SPEECH PATHOLOGY | 4,399 | | | | 68.0 |
| 1.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 6,224 | | | | 71.0 |
| 2.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 367 | | | | 72.0 |
| 3.00 | 07300 DRUGS CHARGED TO PATIENTS | 33,321 | | | | 73.0 |
| į | OUTPATIENT SERVICE COST CENTERS | Action of the second | | A | | , 5.0 |
| | 09000 CLINIC | 60,968 | | | | 90.0 |
| 1.00 | 09100 EMERGENCY | 81,876 | | | | 91.0 |
| 2.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | 92.0 |
| | OTHER REIMBURSABLE COST CENTERS | . 1, | | | | |
| 5.00 | 09500 AMBULANCE SERVICES | 103,507 | | | - | 95.0 |
| 01.00 | 10100 HOME HEALTH AGENCY | 15,038 | | | | 101.0 |
| | SPECIAL PURPOSE COST CENTERS | man man a construction of | | | | |
| | 11300 INTEREST EXPENSE | | | | | 113.0 |
| | 11600 HOSPICE | 0 | | | | 116.0 |
| 18.00 | SUBTOTALS (SUM OF LINES 1-117) | 1,171,129 | | | | 118.0 |
| | WONREIMBURSABLE COST CENTERS | | | | | |
| 90.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 12,577 | | | | 190.0 |
| 92.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 98,180 | | | | 192.0 |
| 92.01 | 19201 MARKETING | 1,504 | | | | 192.0 |
| 00.00 | Cross Foot Adjustments | 0 | | | | 200.0 |
| | | | | | | 200.0 |
| 01.00 | Negative Cost Centers | n | | | | 201.0 |

PITAL In Lieu of Form CMS-2552-10

Provider CCN: 151322 | Period: From 01/01/2012 | To 12/31/2012 | Date/Time Prepared: 5/30/2013 9:13 am

| ner i ne del resime alan i co | A Color Ann Color of the Company and the Color of Color of the Color o | | | | | 5/30/2013 9:1 | 3 am |
|-------------------------------|--|--|--|---|------------|--|--------|
| | | CAPITAL RELA | ATED COSTS | | | The state of the s | |
| | Cost Center Description | NEW BLDG & FIXT (SQUARE FEET) | NEW MVBLE EQUIP (SQUARE FEET) | EMPLOYEE BENEFITS (GROSS SALARIES) | | ADMINISTRATIVE & GENERAL (ACCUM. COST) | |
| | CENEDAL CENTER COST CRITTERS | 1.00 | 2.00 | 4.00 | 5A | 5.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | 1 1 12221 | | | 1 | | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | 88,279 | | | | | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | 88,279 | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS | 868 | 868 | 12,122,328 | | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | 10,556 | 10,556 | 1,810,118 | | 25,270,768 | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | 9,090 | 9,090 | 294,921 | | 2,300,737 | 7.00 |
| 8.00 9.00 | 00800 LAUNDRY & LINEN SERVICE | 1,231 | 1,231 | 908 | , - | , | |
| 10.00 | 00900 HOUSEKEEPING | 456 | 456 | 207,425 | | , | |
| | 01000 DIETARY | 5,882 | 5,882 | 173,894 | | , | |
| 12.00 | | 0 | 0 | 79,517 | | 30,3.0 | |
| 15.00 | 01300 NURSING ADMINISTRATION | 800 | 800 | 553,748 | | | |
| 10.00 | 01600 MEDICAL RECORDS & LIBRARY | 1,746 | 1,746 | 176,080 | 0 | 471,457 | 16.00 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 1 | جهرسورين راسانده | | | | - · |
| | 03000 ADULTS & PEDIATRICS | 17,266 | 17,266 | 1,555,228 | | ,,, | 30.00 |
| | 03100 INTENSIVE CARE UNIT | 1,796 | 1,796 | 271,198 | | 3 12,027 | 31.00 |
| 43.00 | 04300 NURSERY | 323 | 323 | 27,658 | 0 | 32,495 | 43.00 |
| E0.00 | ANCILLARY SERVICE COST CENTERS | f:t= | e e e e e e e e e e e e e e e e e e e | | | | |
| 50.00 | 05000 OPERATING ROOM | 5,612 | 5,612 | 448,693 | | , | |
| 54.00 | 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC | 648 | 648 | 27,307 | | 50,007 | |
| | | 5,320 | 5,320 | 861,744 | | -,, | |
| 62.00 | 06000 LABORATORY | 1,059 | 1,059 | 627,194 | | =,520, 100 | 60.00 |
| 65 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY | 0 | 0 | 10,005 | | ,505 | |
| 66.00 | 06600 PHYSICAL THERAPY | 2,269 | 2,269 | 476,819 | | , | |
| 67.00 | 06700 OCCUPATIONAL THERAPY | 4,066 | 4,066 | 21,380 | | , | |
| 68 00 | 06800 SPEECH PATHOLOGY | 164 | 164 | 0 | | , | |
| | | 164 | 164 | 0 | 0 | , | |
| 72.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 220 | 220 | 45,916 | | , | |
| 72.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 22,.00 | |
| 75.00 | OUTPATIENT SERVICE COST CENTERS | 1,095 | 1,095 | 82,659 | 0 | 2,408,923 | 73.00 |
| 90.00 | 09000 CLINIC | 2 211 | 2 244 | 205 245 | _ | | |
| 91.00 | 09100 EMERGENCY | 3,311 | 3,311 | 205,846 | | , | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 3,347 | 3,347 | 814,578 | 0 | 1,469,979 | |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 95.00 | 09500 AMBULANCE SERVICES | 5,724 | 5,724 | 511,259 | 0 | 1 000 336 | 05.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 588 | 588 | 293,494 | | -,, | |
| | SPECIAL PURPOSE COST CENTERS | 500 | 500 | 255,454 | | 788,015 | 101.00 |
| 113.00 | 11300 INTEREST EXPENSE | · | | | | | 113.00 |
| 116.00 | 11600 HOSPICE | 0 | 0 | O | 0 | | 116.00 |
| 118.00 | | 83,601 | 83,601 | 9,577,589 | -6,216,287 | • | |
| | NONREIMBURSABLE COST CENTERS | * * | | - / / 1 | 0,220,201 | 20,210,007 | 110.00 |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 744 | 744 | 0 | 0 | 10,816 | 190.00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 3,934 | 3,934 | 2,509,621 | 0 | | 192.00 |
| | 19201 MARKETING | 0 | 0 | 35,118 | 0 | 238,728 | 192.01 |
| 200.00 | i | | | | 1 | | 200.00 |
| 201.00 | | 1 | | | | | 201.00 |
| 202.00 | | 1,190,138 | 93,252 | 49,115 | : | 6,216,287 | |
| 203.00 | Part I) | 42 40 | | | | | |
| 204.00 | | 13.481553 | 1.056333 | 0.004052 | | 0.245987 | |
| 207.00 | Part II) | | | 12,619 | | 155,346 | 204.00 |
| 205.00 | | | | 0.001041 | | 0.0065 | 205 00 |
| ; | II) | | | 0.001041 | | 0.006147 | 205.00 |
| | | . 1 | 1 | | | į | |

| CUST A | LLOCATION - STATISTICAL BASIS | | Provider | CCN: 151322 | Period: | Worksheet B-1 | 1 |
|---|--|---|--|-------------|----------------------------------|--|--|
| | | | | | From 01/01/2012 To 12/31/2012 | Date/Time Pre | |
| - compagning of sold for | Cost Center Description | OPERATION OF PLANT (SQUARE FEET) | LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) | FEET) | (MEALS SERVED) | 5/30/2013 9:1 CAFETERIA (FTE'S) | 13 am |
| | GENERAL SERVICE COST CENTERS | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| 1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY | 67,765 1,231 456 5,882 | 24,968 1,680 | 66,07 | 1 | | 1.00 2.00 4.00 5.00 7.00 8.00 9.00 |
| | 01100 CAFETERIA | 0 | 0 | | 0 0 | 12,648 | |
| | 01300 NURSING ADMINISTRATION | 800 | 1 | 1 | 0 0 | 827 | 1 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 1,746 | 0 | 1,74 | 16 0 | 495 | 16.00 |
| 30.00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | 17 366 | 0.011 | 1 | | | |
| 31.00 | 03100 INTENSIVE CARE UNIT | 17,266 1,796 | | 1 | | 3,726 | 1 |
| 43.00 | 04300 NURSERY | 323 | | , | 96 616 23 0 | 497 55 | 1 |
| 1 | ANCILLARY SERVICE COST CENTERS | 1 | | | · J | | 43.00 |
| 50.00 | 05000 OPERATING ROOM | 5,612 | 1,531 | 5,61 | 12 0 | 543 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 648 | 1 | 64 | 18 0 | 53 | |
| | 05400 RADIOLOGY-DIAGNOSTIC | 5,320 | | 1 | 20 0 | 1,591 | 54.00 |
| | 06000 LABORATORY | 1,059 | i | , | ; | 1,470 | |
| 65.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY | 0 2 360 | 0 | ! | 0 0 | 21 | 1 |
| | 06600 PHYSICAL THERAPY | 2,269 4,066 | | , | | 934 | |
| | 06700 OCCUPATIONAL THERAPY | 164 | ! | , | 1 | 94 0 | 1 |
| 68.00 | 06800 SPEECH PATHOLOGY | 164 | ő | | 1 1 | 0 | , |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 220 | . 0 | 22 | | 84 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 0 | 0 | 1 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 1,095 | 0 | 1,09 | 05 | 262 | 73.00 |
| 00.00 | OUTPATIENT SERVICE COST CENTERS 09000 CLINIC | T | | | | A CONTRACTOR OF THE CONTRACTOR | |
| | 09100 EMERGENCY | 3,311 | | 1 | | 477 | 1 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 3,347 | 8,304 | 3,34 | 17 0 | 1,519 | 1 |
| (| OTHER REIMBURSABLE COST CENTERS | I ! | | t | | | 92.00 |
| 95.00 | 09500 AMBULANCE SERVICES | 5,724 | 26 | 5,72 | 14 0 | 0 | 95.00 |
| | 10100 HOME HEALTH AGENCY | 588 | | | | - | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | years and a | | | | | |
| | 11300 INTEREST EXPENSE 11600 HOSPICE | _ | | | | | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1-117) | 62.087 | 0 | 1 | 0 0 | | 116.00 |
| 1 | NONREIMBURSABLE COST CENTERS | 63,087 | 24,954 | 61,40 | 26,580 | 12,648 | 118.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 744 | 0 | 74 | 4 0 | 0 | 190.00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 3,934 | 14 | 1 | 1 77 | | 192.00 |
| | 19201 MARKETING | 0 | 0 | -, | 0 0 | | 192.01 |
| | Cross Foot Adjustments | | | | 1 | - | 200.00 |
| | Negative Cost Centers | 1,979,617 | 177 261 | EGA 77 | 0 051 036 | 142.55 | 201.00 |
| 201.00 | COST to be allocated (nor whether | 1.9/9.01/ | 177,261 | 564,77 | 9 951,936 | 112,562 | 202.00 |
| 201.00 | Cost to be allocated (per wkst. B, Part I) | _,, | | | - 1 | | |
| 201.00 202.00 | Part I) Unit cost multiplier (Wkst. B. Part I) | | 7.099527 | 8 54715 | 6 35 813005 | 8 800500 | 203 00 |
| 200.00 201.00 202.00 203.00 204.00 | Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, | 29.212971 142,222 | 7.099527 21,178 | | | 8.899589 638 | |
| 201.00 202.00 203.00 | Part I) Unit cost multiplier (Wkst. B. Part I) | 29.212971 | 1 | 11,89 | 0 102,696 | | 204.00 |

6,870

897,374

18,313

2.665648

130.622125

0

0

0

272

0

0

0

657,763

32,467

2,418.246324

119.363971

113.00

116.00

118.00

190.00

192.00

192.01

200.00

201.00

202.00

203.00

204.00

205.00

113.00 11300 INTEREST EXPENSE

Part I)

Part II)

II)

SUBTOTALS (SUM OF LINES 1-117)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

NONREIMBURSABLE COST CENTERS
190.00,19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

192.00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

116.00 11600 HOSPICE

192.01 19201 MARKETING

200.00

201.00

202.00

203.00

204.00

205.00

| .UMPUTATION (| OF RATIO OF COSTS TO CHAI | RGES | | Provider | CCN: 151322 | Period: | u of Form CMS- Worksheet C | |
|--|--|--------------------------------|----------------------|------------------------------------|--|--|-------------------------------|------------|
| | | | | | | From 01/01/2012 To 12/31/2012 | Date/Time Pre | pare |
| | | 1 | <u> </u> | Tit1 | e XVIII | Hospita] | 5/30/2013 9:1 Cost | L3 an |
| | Cost Center Description | Total Cost | Therapy Limit | Total Costs | Costs | Total Costs | Charges | |
| | - Description | (from Wkst. B, Part I, col. | | Total Costs | RCE Disallowance | | Inpatient | |
| | | 26) | | e e como aguar gaga e agas | TO THE POLICE A TO THE TO A STREET AND A STREET | | And the second second second | |
| INPATT | ENT ROUTINE SERVICE COST | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| 0.00 03000 | ADULTS & PEDIATRICS | 5,811,846 | | 5,811,846 | | n | 2 250 100 | 20 |
| 1.00 03100 | INTENSIVE CARE UNIT | 587,017 | | 587,017 | | 0 0 | 3,258,198 972,102 | 30 |
| 3.00 04300 N | | 60,834 | | 60,834 | | o o | 107,730 | |
| ANCILL | ARY SERVICE COST CENTERS | | 1 | | | | . == , , , == | 1 |
| 2.00 05200 r | DEFERITING ROOM DELIVERY ROOM & LABOR | 1,440,070 | 1 | 1,440,070 | | 0 0 | 784,238 | |
| | ROOM | 77,800 | | 77,800 | | 0 0 | 234,869 | 52 |
| | RADIOLOGY-DIAGNOSTIC | 3,075,736 | | 3,075,736 | | 0 0 | 2 202 061 | |
| 0.00 06000 ւ | .ABORATORY | 2,114,825 | j | 2,114,825 | | 0 0 | 2,282,061 2,271,622 | |
| | WHOLE BLOOD & PACKED RED | 202,741 | | 202,741 | | o o | 216,725 | |
| 5 00 06500 8 | BLOOD CELLS RESPIRATORY THERAPY | 1 717 004 | _ | | | | , | |
| 5.00 06600 F | PHYSICAL THERAPY | 1,313,864 | | -,, | | 0 | 1,619,691 | |
| 7.00 06700 c | OCCUPATIONAL THERAPY | 784,167 153,813 | | 784,167 | | 0 0 | 388,966 | |
| .00 06800 s | PEECH PATHOLOGY | 208,267 | | 153,813 208,267 | | 0 0 | 221,074 | |
| L.00 07100 M | MEDICAL SUPPLIES CHARGED | 510,218 | | 510,218 | | 0 0 | 73,743 2,106,725 | |
| T 00 07300 | O PATIENTS | | | , | | - | 2,100,723 | ' ' |
| | MPL. DEV. CHARGED TO | 74,470 | | 74,470 | | 0 | 0 | 72 |
| .00 07300 n | RUGS CHARGED TO | 3,045,166 | | 2 045 166 | | _ | | |
| P | ATIENTS | | | 3,045,166 | : | 0 | 5,910,544 | 73 |
| OUTPATI | ENT SERVICE COST CENTERS | • | l I | . 1 | | | | |
| .00 09000 c | LINIC | 682,904 | | 682,904 | | 0 | 2,723 | gr |
| .00 09100 E | MERGENCY | 2,320,738 | | 2,320,738 | | 0 | 289,539 | |
| | BSERVATION BEDS | 541,493 | | 541,493 | | 0 | 29,263 | |
| OTHER R | NON-DISTINCT PART) EIMBURSABLE COST CENTERS | | ļ | ! | | | · | |
| .00 09500 A | MBULANCE SERVICES | 1,573,610 | | 1,573,610 | | , | | |
| 1.00 10100 н | OME HEALTH AGENCY | 1,004,059 | | 1,004,059 | | 0 0 | | 95 |
| SPECIAL | PURPOSE COST CENTERS | , , <u>a</u> , , , , , , , , | | <u> </u> | | ;. O | U | 101 |
| .3.00 11300 I | NTEREST EXPENSE | | | | | | | 113 |
| 6.0011600 н 0.00 s | | 0 | | O | | 0 | : | 116 |
| , | ubtotal (see nstructions) | 25,583,638 | 0 | 25,583,638 | (| 0 | 20,769,813 | 200 |
| | ess Observation Beds | 541,493 | | 541,493 | | | | |
| | otal (see instructions) | 25,042,145 | 0 | 25,042,145 | . (| 0 | 20,769,813 | 201 |
| _ | | Char | | | | 9 | 20,709,613 | 202 |
| C | ost Center Description | Outpatient | Total (col. 6 | | TEFRA | PPS Inpatient | - | |
| | | | + col. 7) | Ratio | Inpatient | Ratio | | |
| | 1 | 7.00 | 8.00 | 9.00 | Ratio | | | |
| INPATIE | NT ROUTINE SERVICE COST | CENTERS | 0.00 | 9.00 | 10.00 | 11.00 | | |
| .00 03000 AI | DULTS & PEDIATRICS | | 3,258,198 | | | | | 20 |
| .00 03100 II | NTENSIVE CARE UNIT | | 972,102 | | | | 1 | 30 31 |
| .00 04300 NI | URSERY | | 107,730 | | | | - | 43 |
| 00 05000 0 | RY SERVICE COST CENTERS PERATING ROOM | 2 602 207 | | The Leader | | | | |
| .00 05200 DI | ELIVERY ROOM & LABOR | 3,883,397 158,495 | 4,667,635 | 0.308522 | 0.000000 | | ! | 50 |
| RO | ООМ | 130,493 | 393,364 | 0.197781 | 0.000000 | 0.000000 | | 52 |
| .00 05400 RA | ADIOLOGY-DIAGNOSTIC | 12,658,249 | 14,940,310 | 0.205868 | 0.000000 | 0.00000 | : | |
| 00 06000 LA | ABORATORY | 6,419,131 | 8,690,753 | 0.243342 | 0.000000 | 1 | 1 | 54 |
| .00 06200 WI | IOLE BLOOD & PACKED RED | 164,614 | 381,339 | 0.531656 | 0.000000 | | 1 | 60 62 |
| 00 06500 pc | OOD CELLS ESPIRATORY THERAPY | 4 | _ | | | | | 02 |
| .00 06600 PL | YSICAL THERAPY | 1,751,283 | 3,370,974 | 0.389758 | 0.000000 | | | 65. |
| 00 06700 oc | CUPATIONAL THERAPY | 1,491,421 346,930 | 1,880,387 568,004 | 0.417024 | 0.000000 | | | 66 |
| 00 06800 SP | PEECH PATHOLOGY | 342,267 | 416,010 | 0.270796 0.500630 | 0.000000 | | | 67 |
| 00 07100 ME | DICAL SUPPLIES CHARGED | 2,483,944 | 4,590,669 | 0.111142 | 0.000000 | | | 68 |
| TO | PATIENTS | | , | | 0.000000 | 0.00000 | | 71. |
| UU U/200 IM | IPL. DEV. CHARGED TO | 53,650 | 53,650 | 1.388071 | 0.000000 | 0.000000 | | 72. |
| | TIENT | 6 775 225 | 13 605 075 | | _ | | | • |
| PA | TIENTS | 6,775,335 | 12,685,879 | 0.240044 | 0.000000 | 0.000000 | | 73. |
| 00 07300 DR | | L | L | man construction when the same and | and the second s | The second secon | Make | |
| 00 07300 DR PA OUTPATIE | INT SERVICE COST CENTERS | The state of the second and | 425 105 | 1.569515 | 0.000000 | 0.000000 | | 00 |
| 00 07300 DR PA OUTPATIE 00 09000 CL | INT SERVICE COST CENTERS | 432,382 | 400.100 | | 0.000000 | V. UUUUUU | | 90. |
| 00 07300 DR PA OUTPATIE 00 09000 CL 00 09100 EM | INIC ERGENCY | 432,382 5,333,194 | 435,105 5,622,733 | | | | | 01 |
| 00 07300 DR PA OUTPATIE 00 09000 CL 00 09100 EM 00 09200 OB | INIC ERGENCY SERVATION BEDS | | | 0.412742 1.504988 | 0.000000 | 0.000000 | | |
| 00 07300 DR PA OUTPATIE 00 09000 CL 00 09100 EM 00 09200 OB | INIC ERGENCY | 5,333,194 | 5,622,733 | 0.412742 | 0.00000 | | | 91. 92. |

| COMPUTATION | OF RATIO OF COSTS TO CHAR | GES | | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | u of Form CMS-2552-10 Worksheet C Part I Date/Time Prepared: 5/30/2013 9:13 am |
|--|--|--|----------------------------|------------------------|--|---|--|
| minutes of the state of the sta | and the second s | والمواد المتحدد ومناه | I I MATERIAL MATERIAL . | Tit | le XVIII | Hospital | Cost |
| | | Char | •ges | | | | |
| | Cost Center Description | Control to the control of the contro | Total (col. 6 + col. 7) | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | 40.00 |
| e e a como o managemento de la companyone de la companyon | grant and a state of the contract was the contract of the cont | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| 101.00 10100 | HOME HEALTH AGENCY | 2,121,397 | 2,121,397 | | to written to the control of the con | annum protest - Transfera. | 101.00 |
| SPECI | AL PURPOSE COST CENTERS | | | h | ale | | 101.00 |
| 116.00 11600 | INTEREST EXPENSE HOSPICE Subtotal (see instructions) | 0 47,019,401 | 0 67,789,214 | | | | 113.00 116.00 200.00 |
| 201.00 202.00 | Less Observation Beds Total (see instructions) | 47,019,401 | 67,789,214 | | | | 201.00 202.00 |

| Health Fi COMPUTATI | nancial Systems ON OF RATIO OF COSTS TO CHA | RGES | PERRY COUNT | | CCN: 151322 | In Lie | u of Form CMS- Worksheet C | 2552-1 |
|------------------------|---|--|--|---|--|---|--|-----------------|
| | | | | riovidei | CCN. 131322 | From 01/01/2012 To 12/31/2012 | Part I | |
| | Commence of the second | • | prose | Tit | le XIX | Hospital | PPS | |
| | Cost Center Description | Total Cost | Thomanu (imin | Tabal 0 | Costs | Printly - contratements and a commence of the contratement of the | Charges | I |
| | cost center seser iperun | (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Disallowance | Total Costs | Inpatient | |
| TNE | PATIENT ROUTINE SERVICE COST | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| 30.00 030 | 000 ADULTS & PEDIATRICS | 5,811,846 | *************************************** | F 011 04C | · · · · · · · · · · · · · · · · · · · | | · · · · · · · · · · · · · · · · · · · | |
| 31.00 031 | 00 INTENSIVE CARE UNIT | 587,017 | i | 5,811,846 587,017 | | 0 5,811,846 0 587,017 | 3,258,198 | |
| 43.00 043 | 100 NURSERY | 60.834 | | 60,834 | | 0 60,834 | 972,102 107,730 | |
| ANC | ILLARY SERVICE COST CENTERS | | | · · · · · · · · · · · · · · · · · · · | | 50,000,0 | 207,730 | 73.00 |
| 2 00 050 | 00 OPERATING ROOM 00 DELIVERY ROOM & LABOR | 1,440,070 | 1 | 1,440,070 | 1 | 0 1,440,070 | 784,238 | 50.00 |
| 2.00 | ROOM ROOM & LABOR | 77,800 | And the second s | 77,800 | | 0 77,800 | 234,869 | 52.00 |
| 4.00 054 | 00 RADIOLOGY-DIAGNOSTIC | 3,075,736 | | 3,075,736 | | 0 3,075,736 | 2 202 001 | F4 04 |
| i0.00 060 | 00 LABORATORY | 2.114.825 | | 2,114,825 | | 0 2,114,825 | 2,282,061 2,271,622 | |
| 2.00 062 | 00 WHOLE BLOOD & PACKED RED | 202,741 | | 202,741 | | 0 202,741 | 216,725 | |
| 5.00 065 | BLOOD CELLS 00 RESPIRATORY THERAPY | 1 313 004 | | | | | , | 02.00 |
| 6.00 066 | 00 PHYSICAL THERAPY | 1,313,864 | | 1,313,864 | | 0 1,313,864 | 1,619,691 | |
| 7.00 067 | 00 OCCUPATIONAL THERAPY | 784,167 153,813 | 0 | 784,167 153,813 | | 0 784,167 | 388,966 | |
| 8.00 068 | 00 SPEECH PATHOLOGY | 208,267 | 0 | 208,267 | | 0 153,813 0 208,267 | 221,074 | |
| 1.00 071 | 00 MEDICAL SUPPLIES CHARGED | 510,218 | • | 510,218 | | 0 208,287 | 73,743 2,106,725 | |
| 3 00 073 | TO PATIENTS | · : | | , , | | 510,210 | 2,100,723 | /1.00 |
| 2.00 0/2 | 00 IMPL. DEV. CHARGED TO PATIENT | 74,470 | | 74,470 | | 0 74,470 | 0 | 72.00 |
| 3.00 073 | 00 DRUGS CHARGED TO | 3,045,166 | | 3,045,166 | | 0 2 2 2 2 2 2 | | |
| | PATIENTS | | | 3,043,100 | | 0 3,045,166 | 5,910,544 | 73.00 |
| OUT | PATIENT SERVICE COST CENTER | S | ! | ! | | ! | | |
| 00 090 | 00 CLINIC | 682,904 | | 682,904 | | 0 682,904 | 2.723 | 90.00 |
| 00 091 | 00 EMERGENCY 00 OBSERVATION BEDS | 2,320,738 | | 2,320,738 | | 0 2,320,738 | 289,539 | |
| 00 032 | (NON-DISTINCT PART) | 541,493 | | 541,493 | | 541,493 | 29,263 | |
| ОТН | ER REIMBURSABLE COST CENTERS | S | | ! | | | | |
| .00 095 | 00 AMBULANCE SERVICES | 1,573,610 | · · · · · · · · · · · · · · · · · · · | 1,573,610 | | 0 1,573,610 | | 05 00 |
| 1.00 101 | 00 HOME HEALTH AGENCY | 1,004,059 | | 1,004,059 | | 1,004,059 | | 95.00 101.00 |
| SPE6 | CIAL PURPOSE COST CENTERS | | | , | | 2,007,035 | | 101.00 |
| 6 00 116 | 00 INTEREST EXPENSE 00 HOSPICE | | | | | | I | 113.00 |
| 0.00 | Subtotal (see | 25,583,638 | | 0 | | 0 | 0 | 116.00 |
| | instructions) | 23,303,036 | 0 | 25,583,638 | | 0 25,583,638 | 20,769,813 | 200.00 |
| 1.00 | Less Observation Beds | 541,493 | | 541,493 | | 541,493 | | 201.00 |
| 2.00 | Total (see instructions) | 25,042,145 | 0 | 25,042,145 | + | 0 25,042,145 | 20,769,813 | |
| | Cost Center Description | Char | | | | | ,, | 202,.00 |
| | cost center bescription | | Total (col. 6 + col. 7) | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | | |
| TNPA | TIENT ROUTINE SERVICE COST | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | | |
| .00 0300 | 0 ADULTS & PEDIATRICS | CENTERS | 3 250 100 | | | 17 77 | | |
| .00 0310 | 0 INTENSIVE CARE UNIT | | 3,258,198 972,102 | | | | | 30.00 |
| .00 0430 | 0 NURSERY | | 107,730 | | ¥- | | | 31.00 |
| ANCI | LLARY SERVICE COST CENTERS | and the second second | and the second section of the second | | | 4 | | 43.00 |
| .00 USUO | O OPERATING ROOM O DELIVERY ROOM & LABOR | 3,883,397 | 4,667,635 | 0.308522 | 0.000000 | 0.308522 | | 50.00 |
| , 55 (0520 | ROOM & LABOR | 158,495 | 393,364 | 0.197781 | 0.000000 | | | 52.00 |
| .00 0540 | 0 RADIOLOGY-DIAGNOSTIC | 12,658,249 | 14,940,310 | 0.205868 | 0.00000 | 0 20505- | 1 | |
| .00 0600 | 0 LABORATORY | 6,419,131 | 8,690,753 | 0.243342 | 0.000000 | | | 54.00 |
| .00 0620 | O WHOLE BLOOD & PACKED RED | 164,614 | 381,339 | 0.531656 | 0.000000 | | Í | 60.00 |
| | BLOOD CELLS O RESPIRATORY THERAPY | | | | 0.000000 | 0.75000 | | 62.00 |
| .00 0650 | O PHYSICAL THERAPY | 1,751,283 | 3,370,974 | 0.389758 | 0.000000 | | w Large C. | 65.00 |
| .00 0670 | O OCCUPATIONAL THERAPY | 1,491,421 346,930 | 1,880,387 | 0.417024 | 0.000000 | | | 66.00 |
| 00 0680 | 0 SPEECH PATHOLOGY | 342,267 | 568,004 416,010 | 0.270796 0.500630 | 0.000000 | | ļ | 67.00 |
| 00 0710 | O MEDICAL SUPPLIES CHARGED | 2,483,944 | 4,590,669 | 0.111142 | 0.000000 | | | 68.00 |
| 00 0720 | TO PATIENTS O IMPL. DEV. CHARGED TO | | ĺ | | 0.00000 | 0.111142 | | 71.00 |
| | PATIENT | 53,650 | 53,650 | 1.388071 | 0.000000 | 1.388071 | I | 72.00 |
| 00 0730 | O DRUGS CHARGED TO | 6,775,335 | 12,685,879 | 0.240044 | 0.000000 | 0.34004 | | |
| 21 - 1 - 2 - | PATIENTS | 2,.,5,555 | ,000,079 | 0.240044 | 0.000000 | 0.240044 | | 73.00 |
| OUTP | ATIENT SERVICE COST CENTERS | The second secon | recommendation of the state of | | Annual Communication of the Co | Proposed to a consequence of consequence of the design | The second secon | |
| 00 0900 | D CLINIC D EMERGENCY | 432,382 | 435,105 | 1.569515 | 0.000000 | 1.569515 | | 90.00 |
| 00 0920 | O OBSERVATION BEDS | 5,333,194 | 5,622,733 | 0.412742 | 0.000000 | 0.412742 | 1 | 91.00 |
| | (NON-DISTINCT PART) | 330,536 | 359,799 | 1.504988 | 0.000000 | 1.504988 | 1 | 92.00 |
| OTHE | REIMBURSABLE COST CENTERS | | | <u> </u> | The Maria Committee of the Committee of | | | |
| 00 09500 | AMBULANCE SERVICES | 2,273,176 | 2,273,176 | 0.692252 | 0.000000 | 0.692252 | | 05 00 |
| | | | | | 00000 | 0.032232 | | 95.00 |

| Health Financial Systems | | PERRY COUNT | Y HOSPITAL | | In Lie | u of Form CMS | -2552-10 |
|--|-----------------|----------------------------|------------------------|-----------------------------|--|--|----------------------------|
| COMPUTATION OF RATIO OF COSTS TO CHAP | RGES | | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | | |
| | | | Tit | le XIX | Hospital | PPS | |
| | Chai | rges | | | | | |
| Cost Center Description | Outpatient | Total (col. 6 + col. 7) | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | A January Machine and the Company of | |
| | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | A STATE OF THE PROPERTY OF PARTY | |
| 101.00 10100 HOME HEALTH AGENCY | 2,121,397 | 2,121,397 | | | The second secon | # 1 * 1 * 1 * 1 * 1 * 1 * 1 * 1 * 1 * 1 | 101.00 |
| SPECIAL PURPOSE COST CENTERS | 2 | | | | | | |
| 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) | 0 47,019,401 | 67,789,214 | | | | u memoden na sa managan dalam iu. | 113.00 116.00 200.00 |
| 201.00 Less Observation Beds 202.00 Total (see instructions) | 47,019,401 | 67,789,214 | | | | | 201.00 202.00 |

| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F REDUCTIONS FOR MEDICAID ONLY | RATIOS NET OF | | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | wof Form CMS- Worksheet C Part II Date/Time Pro 5/30/2013 9: | epared: |
|--|--|---|--|---|--|---------|
| The second secon | 7 41 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | tle XIX | Hospital | PPS | |
| Cost Center Description | Total Cost | Capital Cost | Operating Cos | t Capital | Operating Cost | 1 |
| | (Wkst. B, Part | (Wkst. B, Part | Net of Capita | 1 Reduction | Reduction | • |
| | I, col. 26) | II col. 26) | Cost (col. 1 | - | Amount | |
| | | | col. 2) | | ruii o o i i c | |
| American registration of the control | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCILLARY SERVICE COST CENTERS | | The second second second second second second | ale annument in Table 1987 in the same | | 3.00 | |
| 0.00 05000 OPERATING ROOM | 1,440,070 | 103,246 | 1,336,82 | 4 | | FO 0 |
| 2.00 05200 DELIVERY ROOM & LABOR ROOM | 77,800 | , | | | C | 1 |
| 4.00 05400 RADIOLOGY-DIAGNOSTIC | 3,075,736 | ,, | | | 0 | 3 |
| 0.00 06000 LABORATORY | 2,114,825 | , | | | 0 | |
| 2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 202,741 | | , , | | 0 | 60.0 |
| 5.00 06500 RESPIRATORY THERAPY | 1,313,864 | | | | 0 | 62.0 |
| 6.00 06600 PHYSICAL THERAPY | 784,167 | | | | 0 | 65.0 |
| 7.00 06700 OCCUPATIONAL THERAPY | 153,813 | | | | 0 | 66.0 |
| 8.00 06800 SPEECH PATHOLOGY | 208,267 | -, | | | 0 | 67.0 |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | j . | , ,,,,, | , | | 0 | 68.0 |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENT | 510,218 | -,, | , | | 0 | 71.0 |
| 3.00 07300 DRUGS CHARGED TO PATIENTS | 74,470 | | , | | 0 | 72.0 |
| OUTPATIENT SERVICE COST CENTERS | 3,045,166 | 33,321 | 3,011,84 | 5 0 | 0 | 73.0 |
| 0.00 09000 CLINIC | The ore against a | er come come and a super- | y | | | |
| 1.00 09100 EMERGENCY | 682,904 | , | | 6 | 0 | 90.0 |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 2,320,738 | | 2,238,86 | 2 0 | 0 | : |
| OTHER REIMBURSABLE COST CENTERS | 541,493 | 0 | 541,49 | 3 0 | 0 | 1 |
| 5.00 09500 AMBULANCE SERVICES | | | | ••• | | 1 2 |
| 01.00 10100 HOME HEALTH AGENCY | 1,573,610 | | 1,470,10 | 3 0 | 0 | 95.0 |
| SPECTAL PURPOSE SOCT STATES | 1,004,059 | 15,038 | 989,023 | 1 0 | | 101.0 |
| SPECIAL PURPOSE COST CENTERS 13.00 11300 INTEREST EXPENSE | PATE | | | 7 11 1 1 1 1 1 1 1 1 | | 101.0 |
| IS OUTTOOM THIERES! EXPENSE | | | | 1 | | 113.0 |
| 16.00 11600 HOSPICE | 0 | 0 | (| 0 | | 116.0 |
| The state of the s | 19,123,941 | 694,586 | 18,429,35 | 5 0 | | 200.0 |
| 01.00 Less Observation Beds | 541,493 | 0 | 541,49 | | | |
| D2.00 Total (line 200 minus line 201) | 18,582,448 | 694,586 | | 2 0 | | 201.00 |

| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY | RATIOS NET OF | | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part II Date/Time Pr 5/30/2013 9: | |
|---|---|--------------------------------|---------------|--|--|-------|
| Cost Center Description | Cost Net of Capital and Operating Cost Reduction 6.00 | Total Charges (Worksheet C, | Cost to Charg | | PPS | |
| ANCILLARY SERVICE COST CENTERS | | 1 700 | 0.00 | A management of the contract o | magnetic and the | |
| 50.00 05000 OPERATING ROOM | 1,440,070 | 4,667,635 | 0.30852 | 2 | | 50.0 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 77,800 | | | 1 | | 52.0 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 3,075,736 | | | | | 54.0 |
| 0.00 06000 LABORATORY | 2,114,825 | | | | | 60.0 |
| 2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 202.741 | | | | | 62.0 |
| 5.00 06500 RESPIRATORY THERAPY | 1,313,864 | | | | | 65.0 |
| 6.00 06600 PHYSICAL THERAPY | 784,167 | 1,880,387 | | | | 66.0 |
| 7.00 06700 OCCUPATIONAL THERAPY | 153,813 | 568,004 | 0.27079 | 06 | | 67.0 |
| 8.00 06800 SPEECH PATHOLOGY | 208,267 | 416,010 | 0.50063 | 30 | | 68.0 |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 510,218 | 4,590,669 | 0.11114 | 12 | | 71.0 |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENT | 74,470 | 53,650 | 1.38807 | ' 1 | | 72.0 |
| 3.00 07300 DRUGS CHARGED TO PATIENTS | 3,045,166 | 12,685,879 | 0.24004 | 14 | | 73.0 |
| OUTPATIENT SERVICE COST CENTERS | | | | f a marrier to | | |
| 0.00 09000 CLINIC | 682,904 | 435,105 | 1.56951 | 15 | | 90.0 |
| 1.00 09100 EMERGENCY | 2,320,738 | | 0.41274 | 12 | | 91.0 |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 541,493 | 359,799 | 1.50498 | 88 | | 92.0 |
| OTHER REIMBURSABLE COST CENTERS | r 5 | | 1.1.1 | | | |
| 5.00 09500 AMBULANCE SERVICES | 1,573,610 | 1 | i e | | | 95.0 |
| 01.00 10100 HOME HEALTH AGENCY | 1,004,059 | 2,121,397 | 0.47330 |)1! | | 101. |
| SPECIAL PURPOSE COST CENTERS | | g | | | | |
| 13.00 11300 INTEREST EXPENSE | _ | _ | | | | 113.0 |
| 16.00 11600 HOSPICE 00.00 Subtotal (sum of lines 50 thru 199) | 0 | 0 | 0.00000 | 00 | | 116.0 |
| ((() | 19,123,941 | | | | | 200.0 |
| ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; | 541,493 | | | | | 201.0 |
| Total (line 200 minus line 201) | 18,582,448 | 63,451,184 | | | | 202. |

| APPORTIONMENT C | F INPATIENT ANCILLARY SERVICE CAPI | PERRY COUNT | | | | | u of Form CMS- | 2552-1 |
|-----------------|--|---|----------|------------------|--------------|--|----------------|--------|
| | - THE PROPERTY SERVICE CAPT | IAL COSTS | | Provider | CCN: 151322 | Period: From 01/01/2012 | Worksheet D | |
| | | | | | | To 12/31/2012 | | narad. |
| | | | | | | , 51, 1011 | 5/30/2013 9:1 | .3 am |
| Cos | t Center Description | 1 ********** | , L | | e XVIII | Hospital | Cost | - |
| • | a delicer beschiption | Capital | Total | Charges | Ratio of Cos | | Capital Costs | |
| | | Related Cost | (Trom | Wkst. C, | to Charges | Program | (column 3 x | |
| | | (from Wkst. B, | Part | I, col. | | 1. Charges | column 4) | |
| | | Part II, col. 26) | 1 | 8) | 2) | | | |
| | and the same of th | 1.00 | 2 | .00 | 3.00 | 4.00 | 5.00 | ļ |
| ANCILLARY | SERVICE COST CENTERS | manuf to constitute an accommon to a total constraining plan or | waterman | ANTAL ANALONA | 1 | 7.00 | 3.00 | |
| 50.00 05000 OPE | RATING ROOM | 103,246 | 4 | ,667,635 | 0.0221 | 20 173,120 | 2 020 | E0 00 |
| 52.00 05200 DEL | IVERY ROOM & LABOR ROOM | 11,297 | | 393,364 | | | -, | |
| 54.00 05400 RAD | IOLOGY-DIAGNOSTIC | 113,644 | 14 | ,940,310 | | | 0 | |
| 0.00 06000 LAB | | 36,178 | | ,690,753 | | | -, | |
| 52.00 06200 who | LE BLOOD & PACKED RED BLOOD CELLS | 1,010 | | 381,339 | | ;,,-,-,-, | | |
| 55.00 06500 RES | PIRATORY THERAPY | 46,784 | 3 | ,370,974 | | | | |
| 6.00 06600 PHY | SICAL THERAPY | 73,241 | | .880.387 | | -,, | 16,960 | |
| 7.00 06700 occ | UPATIONAL THERAPY | 3,486 | | 568,004 | | | 7,869 | |
| 8.00 06800 SPE | ECH PATHOLOGY | 4,399 | | 416.010 | | | 609 652 | |
| 1.00 07100 MED | ICAL SUPPLIES CHARGED TO PATIENTS | 6,224 | 4 | .590,669 | | -, -, -, | | |
| 2.00 07200 IMP | . DEV. CHARGED TO PATIENT | 367 | | 53.650 | | -, -, -, -, -, -, -, -, -, -, -, -, -, - | 1,502 | |
| 3.00 0/300 DRU | GS CHARGED TO PATIENTS | 33,321 | 12 | ,685,879 | | | 0 506 | |
| OUTPATIEN | T SERVICE COST CENTERS | | | * v sekator 1.73 | | 212001403 | 8,586 | 73.00 |
| 0.00 09000 CLI | NIC | 60,968 | | 435,105 | 0.14012 | 2 226 | 27 | 00.00 |
| 1.00 09100 EMEI | RGENCY | 81,876 | 5 | ,622,733 | | | 32 143 | |
| 2.00 09200 OBSI | RVATION BEDS (NON-DISTINCT PART) | 0 | | 359,799 | | - 5,050 | | |
| OTHER REI | MBURSABLE COST CENTERS | | | | 2.0000 | Yr | | 92.00 |
| OO OO | JLANCE SERVICES | | | - 1 | | | | 05.00 |
| 200.00 Tota | ıl (lines 50-199) | 576,041 | 59 | 056,611 | | 8,452,463 | E2 F0F | 95.00 |
| | | , , | | , | | 0,432,403 | 52,585 | 200.00 |

| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS | | | Provider CCN: 151322 | | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Prepar 5/30/2013 9:13 a | |
|--|--------------------------------------|--------|---------------------------------|--------------------------|---|---|---------|
| Cost Center Description | Non Physician Anesthetist Cost | | g School | e XVIII Allied Healt | Hospital h All Other Medical Education Cost | Cost Total Cost (sum of col 1 through col. 4) | |
| The Control of the Co | 1.00 | 2 | .00 | 3.00 | 4.00 | 5.00 | |
| ANCILLARY SERVICE COST CENTERS | | _1 | | porter and the second | gyman dan | p | |
| 50.00 O5000 OPERATING ROOM 52.00 O5200 DELIVERY ROOM & LABOR ROOM | | 0 | 0 | | 0 | C | 50. |
| The state of the s | 9 | 0 | 0 | | 0 | C | 52. |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC 50.00 06000 LABORATORY | 9 | 0 | U | | 0 | . 0 | 54. |
| 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | | 0 | 0 | | 0 | C | 60. |
| 55.00 06500 RESPIRATORY THERAPY | | 0 | U | | 0 | | 62. |
| 56.00 06600 PHYSICAL THERAPY | | 0 | 0 | | 0 | C | 65. |
| 57.00 06700 OCCUPATIONAL THERAPY | | U O | 0 | | 0 | į C | 66. |
| 58.00 06800 SPEECH PATHOLOGY | | 0 | U | | 0 | 9 | 67. |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0 | 0 | | 0 | | 68. |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | | 0 | 0 | | 0 | | 71. |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0 | 0 | | 0 | C | , , - , |
| OUTPATIENT SERVICE COST CENTERS | | J | | | <u>u</u> | · | 73. |
| 00.00 09000 CLINIC | | n | Λ | | 0 | į | 90. |
| 01.00 09100 EMERGENCY | | n n | n | | 0 0 | 0 | |
| 22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | o l | 0 | | 0 0 | | 1 ' |
| OTHER REIMBURSABLE COST CENTERS | | -, | · · · · · · · · · · · · · · · · | | | : · | JZ. |
| 05.00 09500 AMBULANCE SERVICES | 1 | i | | - | | i | 95. |
| 200.00 Total (lines 50-199) | | ol | 0 | | 0 0 | | 200. |

| APPORT | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PAS | s | Provider | CCN: 151322 | Period: | u of Form CMS- Worksheet D | |
|--------|--|-----------------|------------|--------------------|---------------|-----------------|--------------------------------|-----------------|
| THROUG | SH COSTS | | | | | From 01/01/2012 | Part IV | |
| | | | | | | To 12/31/2012 | Date/Time Pre 5/30/2013 9:1 | pared: .3 am |
| | A CONTRACTOR OF THE PARTY OF TH | g | , <u>l</u> | | e XVIII | Hospital | Cost | |
| | Cost Center Description | Total | | | Ratio of Cos | | Inpatient | |
| | | Outpatient | | | to Charges | Ratio of Cost | Program | |
| | | Cost (sum of | | | (col. 5 + col | | Charges | |
| | | col. 2, 3 and | | 8) | 7) | (col. 6 ÷ col. | | |
| | | 6.00 | <u>-</u> | | | 7) | 199645-000-1 | |
| | ANCILLARY SERVICE COST CENTERS | D.00 | 1 | .00 | 8.00 | 9.00 | 10.00 | |
| 50.00 | 05000 OPERATING ROOM | | | cen enr | 0.0000 | 0.00000 | | |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 4 | ,667,635 | | | 173,120 | |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | 0 | 1 1 | 393,364 940,310 | | | 0 | 52.00 |
| 60.00 | 06000 LABORATORY | 0 | 1 | , - , - , | | | 862,980 | |
| | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | C | 381,339 381,339 | | | 1,327,946 | |
| 65.00 | 06500 RESPIRATORY THERAPY | 0 | , | ,370,974 | | | 116,962 | |
| | 06600 PHYSICAL THERAPY | 0 | | ,880,387 | | | 1,222,088 | |
| | 06700 OCCUPATIONAL THERAPY | 0 | 1 | 568,004 | | | 202,038 | , |
| | 06800 SPEECH PATHOLOGY | | | 416.010 | | | 99,232 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS |) o | 1 | ,590,669 | | | 61,624 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 7 | 53,650 | | | 1,107,920 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 12 | .685.879 | | | 3,268,489 | |
| | OUTPATIENT SERVICE COST CENTERS | | · | ,005,075 | 0.00000 | 0.000000 | 3,200,409 | 73.00 |
| | 09000 CLINIC | 0 | | 435,105 | 0.00000 | 0.000000 | 226 | 90.00 |
| 91.00 | 09100 EMERGENCY | ŏ | 5 | ,622,733 | | | 9.838 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | o | , | 359,799 | | | 9,030 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | * | les ex e | 222,.22 | 3.00000 | 3.000000 | | 92.00 |
| | 09500 AMBULANCE SERVICES | ì | | | | 1 | | 95.00 |
| 200.00 | Total (lines 50-199) | 0 | 50 | ,056,611 | | 1 | 8,452,463 | |

| 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.197781 0 0 0 0 0 554.00 RADIOLOGY-DIAGNOSTIC 0.205868 0 4,185,206 0 0 0 0 0 0 0 0 0 | Health Financial Systems | PERRY COUNT | Y HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|--|--|----------------------------|----------------------|--|---|-------------------------|----------------|
| Cost Center Description | APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN | D VACCINE COST | | | From 01/01/2012 | Part V Date/Time Pre | pared: 3 am |
| Cost Center Description | The state of the s | | Titl | e XVIII | Hospital | Cost | |
| Ratio From Worksheet C, Part I, col. 9 Services (see inst.) Services (see inst.) Services (see inst.) Services (see inst.) Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & See Inst. Subject To Ded. & See Inst. Subject T | | | | | | Costs | |
| ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 | Cost Center Description | Ratio From Worksheet C, | Services (see inst.) | Reimbursed Services Subject To Ded. & Coins | Reimbursed Services Not Subject To Ded. & Coins. | | |
| ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.308522 0 1,203,004 0 0 5,500 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 1 00 | 2 00 | | | 5 00 | |
| 50.00 05000 0PERATING ROOM 0.308522 0 1,203,004 0 0 55200 05200 DELIVERY ROOM & LABOR ROOM 0.197781 0 0 0 0 0 55200 05400 RADIOLOGY-DIAGNOSTIC 0.205868 0 4,185,206 0 0 0 0 6600 0.480RATORY 0.243342 0 2,643,782 0 0 6600 0.6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.531656 0 132,584 0 0 66 66.00 0.6500 RESPITATIORY THERAPY 0.389758 0 748,413 0 0 66 66.00 0.6500 RESPITATIORY THERAPY 0.417024 0 566,342 0 0 66 66.00 0.6700 OCCUPATIONAL THERAPY 0.270796 0 75,235 0 0 66 68.00 0.6800 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66 68.00 0.6800 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66 67.00 0.700 0. | ANCILLARY SERVICE COST CENTERS | 1.00 | 12.00 | 3.00 | 4.00 | 3.00 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.197781 0 0 0 0 55400 RADIOLOGY-DIAGNOSTIC 0.205868 0 4,185,206 0 0 0 5600 06000 LABORATORY 0.243342 0 2,643,782 0 0 06000 06000 LABORATORY 0.331656 0 132,584 0 0 66000 06500 RESPIRATORY THERAPY 0.389758 0 748,413 0 0 66000 06600 PHYSICAL THERAPY 0.417024 0 566,342 0 0 66000 06600 PHYSICAL THERAPY 0.270796 0 75,235 0 0 66000 06600 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66000 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 0 0 0 0 0 0 0 | | 0.308522 |) | 1 203 00 | 04: | n | 50.00 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.205868 0 4,185,206 0 0 560.00 06000 LABORATORY 0.243342 0 2,643,782 0 0 60600 06000 LABORATORY THERAPY 0.389758 0 748,413 0 0 60600 060000 06000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 0600000 0600000 06000000 060000000 060000000 0600000000 | | | | | | 0 | 52.00 |
| 60.00 06000 LABORATORY 0.243342 0 2,643,782 0 0 66 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.531656 0 132,584 0 0 66 65 00 06500 RESPIRATORY THERAPY 0.389758 0 748,413 0 0 66 66 00 06 00 00 | | | | 4.185.20 | | ő | 54.00 |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.531656 0 132,584 0 0 6650 06500 RESPIRATORY THERAPY 0.417024 0 566,342 0 0 66 00 06700 00 00 0 | | | 1 | | | ő | 60.00 |
| 66.00 06600 PHYSICAL THERAPY 0.417024 0 566,342 0 0 66 67.00 06700 OCCUPATIONAL THERAPY 0.270796 0 75,235 0 0 66 68.00 06800 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.111142 0 753,194 0 0 77 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1.388071 0 52,725 0 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 77 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 1.569515 0 39,004 0 0 99 91.00 09100 EMERGENCY 0.412742 0 1,125,962 0 0 99 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.504988 0 302,992 0 0 99 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.692252 0 15,628,324 14,067 0 200 CONTO SUBTORIAL (See instructions) 1.5628,324 14,067 0 200 CONTO CHARGED TO PATIENTS O.692252 0 15,628,324 14,067 0 200 CONTO CHARGED TO PATIENTS O.692252 0 15,628,324 14,067 0 200 CONTO CHARGED TO PATIENTS O.692252 0 15,628,324 14,067 0 200 CONTO CHARGED TO PATIENTS O.692252 0 15,628,324 14,067 0 200 CONTO CHARGED TO PATIENTS O.692252 0 15,628,324 14,067 0 200 CONTO CHARGED TO PATIENTS O.692252 0 15,628,324 14,067 0 200 CONTO CHARGED TO PATIENTS O.692252 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0.531656 | 0 | | | 0 | 62.00 |
| 67.00 06700 OCCUPATIONAL THERAPY 0.270796 0 75,235 0 0 668.00 06800 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 677.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.111142 0 753,194 0 0 77.00 07200 IMPL. DEV. CHARGED TO PATIENT 1.388071 0 52,725 0 0 77.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 77.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 77.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 77.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 77.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 90.00 09000 CLINIC 0 1.569515 0 39,004 0 0 99.00 09000 EMERGENCY 0.412742 0 1,125,962 0 0 99.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.504988 0 302,992 0 0 99.00 07HER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.692252 0 99.00 09500 AMBULANCE SERVICES 0.692252 0 99.00 09500 AMBULANCE SERVICES 0.692252 0 99.00 09500 AMBULANCE SERVICES 0.692252 0 99.00 09500 AMBULANCE SERVICES 0.692252 0 99.00 099.00 CLESS PBP Clinic Lab. Services-Program 0.019 Charges | 65.00 06500 RESPIRATORY THERAPY | 0.389758 | . 0 | 748,41 | .3 0 | 0 | 65.00 |
| 68.00 06800 SPEECH PATHOLOGY 0.500630 0 29,918 0 0 66 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.111142 0 753,194 0 0 77 72.00 07200 IMPL DEV. CHARGED TO PATIENT 1.388071 0 52,725 0 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 77 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 1.569515 0 39,004 0 0 90 91.00 09100 EMERGENCY 0.412742 0 1,125,962 0 0 90 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.504988 0 302,992 0 0 90 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.692252 0 90 000 Class PBP Clinic Lab. Services-Program 0 0 15,628,324 14,067 0 200 0019 Charges | | 0.417024 | 0 | 566,34 | 12 0 | 0 | 66.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.111142 0 753,194 0 0 772.00 07200 IMPL. DEV. CHARGED TO PATIENT 1.388071 0 52,725 0 0 773.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 775.00 0 | | 0.270796 | 0 | 75,23 | 0 | 0 | 67.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1.388071 0 52,725 0 0 773.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 773.00 001704TIENT SERVICE COST CENTERS 0 09000 CLINIC 0.412742 0 1,125,962 0 0 99000 09000 | | 0.500630 | 0 | 29,91 | .8 0 | 0 | 68.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0.240044 0 3,769,963 14,067 0 7. OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 1.569515 0 39,004 0 0 99 92.00 09100 EMERGENCY 0.412742 0 1,125,962 0 0 99 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.692252 0 99 200.00 Subtotal (see instructions) 0 15,628,324 14,067 0 200 CONTRACTOR OF THE PROPERTY OF THE PROPER | | | | 753,19 | 0 | 0 | 71.00 |
| OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 1.569515 0 39,004 0 0 99 91.00 09100 EMERGENCY 0.412742 0 1,125,962 0 0 99 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.504988 0 302,992 0 0 99 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.692252 0 99 200.00 Subtotal (see instructions) 0 15,628,324 14,067 0 200 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | 52,72 | | 0 | 72.00 |
| 90.00 09000 CLINIC 1.569515 0 39,004 0 0 9900 09100 EMERGENCY 0.412742 0 1,125,962 0 0 9900 09200 085ERVATION BEDS (NON-DISTINCT PART) 1.504988 0 302,992 0 0 9900 09500 | | 0.240044 | 0 | 3,769,96 | 14,067 | 0 | 73.00 |
| 91.00 09100 EMERGENCY 0.412742 0 1,125,962 0 0 9 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.504988 0 302,992 0 0 9 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.692252 0 9 200.00 Subtotal (see instructions) 0 15,628,324 14,067 0 200 201.00 Less PBP Clinic Lab. Services-Program Only Charges | | | | | 4 | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.504988 0 302,992 0 0 9; OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.692252 0 9: 200.00 Subtotal (see instructions) 0 15,628,324 14,067 0 200; 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 1 | - | | | _ | |
| OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.692252 0 99 200.00 Subtotal (see instructions) 0 15,628,324 14,067 0 200 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 200 | | | 1 | | | 0 | |
| 95.00 09500 AMBULANCE SERVICES 0.692252 0 99.00.00 Subtotal (see instructions) 0 15,628,324 14,067 0 200.00 Less PBP Clinic Lab. Services-Program 0 001y Charges | | 1.504988 | 0 | 302,99 | 0 | . 0 | 92.00 |
| 200.00 Subtotal (see instructions) 0 15,628,324 14,067 0 200 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 | | 0 602252 | | | oi | | 05.00 |
| 201.00 Less PBP Clinic Lab. Services-Program 0 0 200 | | 0.092232 | 1 | 15 630 35 | 14 067 | • | 95.00 |
| Only Charges | (000 1110 110) | | 0 | 13,628,32 | 14,067 | 0 | |
| | | | | | U _j | | 201.00 |
| | 202.00 Net Charges (line 200 +/- line 201) | | 0 | 15,628,32 | 14,067 | 0 | 202.00 |

| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN | D VACCINE COST | | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepare 5/30/2013 9:13 am |
|--|--|-------------|-------------|---|---|
| Control of the contro | | | e XVIII | Hospital | Cost |
| Cost Center Description | Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00 | (see inst.) | | | |
| ANCILLARY SERVICE COST CENTERS | 5.00 | 7.00 | L | president Append | |
| 0.00 05000 OPERATING ROOM | 371,153 | | | | |
| 2.00 05200 DELIVERY ROOM & LABOR ROOM | 5, 1, 155 | 0 | | | 50. |
| 4.00 05400 RADIOLOGY-DIAGNOSTIC | 861,600 | 0 | | | 52. |
| 0.00 06000 LABORATORY | 643,343 | 0 | | | 54. |
| 2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 70,489 | ő | | | 60. 62. |
| 5.00 06500 RESPIRATORY THERAPY | 291,700 | 0 | | | 65. |
| 6.00 06600 PHYSICAL THERAPY | 236,178 | ő | | | 66. |
| 7.00 06700 OCCUPATIONAL THERAPY | 20,373 | Ō | | | 67. |
| 8.00 06800 SPEECH PATHOLOGY | 14,978 | 0 | | | 68. |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 83,711 | 0 | | | 71. |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENT | 73,186 | 0 | | | 72. |
| 3.00 07300 DRUGS CHARGED TO PATIENTS | 904,957 | 3,377 | | | 73. |
| OUTPATIENT SERVICE COST CENTERS 0.00 09000 CLINIC | | | | | |
| 1.00 09100 EMERGENCY | 61,217 | 0 | | | 90. |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 464,732 | 0 | | | 91. |
| OTHER REIMBURSABLE COST CENTERS | 455,999 | 0 | | | 92. |
| 5.00 09500 AMBULANCE SERVICES | 1 | | | | |
| 00.00 Subtotal (see instructions) | 4 552 616 | 7 777 | | | 95. |
| 01.00 Less PBP Clinic Lab. Services-Program | 4,553,616 | 3,377 | | | 200. |
| Only Charges | U | design | | | 201. |
| | | | | | |

| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A | PERRY COUNT | | 151000 T | <u>In Lie</u> | u of Form CMS | 2552-1 |
|--|----------------------|-------------------------------|----------------------------|----------------------------------|--------------------------|---------|
| , see a service of | AND ANCEINE COST | Provider | CCN: 151322 | Period: | Worksheet D | |
| | | Componen | t CCN: 15Z322 | From 01/01/2012 To 12/31/2012 | Part V Date/Time Pro | |
| | · | | | 10 12/31/2012 | 5/30/2013 9: | eparea: |
| and the same of the same and the same of the same of the same of the same of the same of the same of the same of | | Tit] | e_XVIII | Swing Beds - SNF | Cost | LJ 41/1 |
| Cost Center Description | Contact of | | Charges | 70.500.00 | Costs | 1 |
| s sanda besti iperon | Ratio From | PPS Reimbursed | | Cost | PPS Services | |
| | Worksheet C, | Services (see | | Reimbursed | (see inst.) | |
| | Part I, col. 9 | inst.) | Services | Services Not | | |
| | | | Subject To Ded. & Coins | Subject To | | |
| | | | (see inst.) | | | 1 |
| the state of the s | 1.00 | 2.00 | 3.00 | (see inst.) 4.00 | P | |
| ANCILLARY SERVICE COST CENTERS | | Lance Control Control Control | | 4.00 | 5.00 | |
| 50.00 05000 OPERATING ROOM | 0.308522 | 0 | A Section of the Community | 0 0 | | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0.197781 | o | | 0 0 | 0 | 00.00 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC 50.00 06000 LABORATORY | 0.205868 | o | | 0 | 0 | , ,,,,, |
| | 0.243342 | 0 | | 0 0 | 0 | 54.00 |
| 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 55.00 06500 RESPIRATORY THERAPY | 0.531656 | 0 | i | o o | 0 | 60.00 |
| 66.00 06600 PHYSICAL THERAPY | 0.389758 | 0 | į. | 0 0 | 0 | 65.00 |
| 7.00 06700 OCCUPATIONAL THERAPY | 0.417024 | 0 | | o o | 0 | 66.00 |
| 88.00 06800 SPEECH PATHOLOGY | 0.270796 | O | (| o o | 0 | 67.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0.500630 | 0 | . (| 0 | 0 | 68.00 |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0.111142 | 0 | (| 0 | o o | 71.00 |
| 3.00 07300 DRUGS CHARGED TO PATIENTS | 1.388071 | 0 | (| 0 | ō | 72.00 |
| OUTPATIENT SERVICE COST CENTERS | 0.240044 | 0 | | 0 | 0 | 73.00 |
| 0.00 09000 CLINIC | 1 500545 | _3 | | | | |
| 1.00 09100 EMERGENCY | 1.569515 0.412742 | 0 | (| 7 | 0 | 90.00 |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1.504988 | 0 | (| 0 | 0 | 91.00 |
| OTHER REIMBURSABLE COST CENTERS | 1 1.304900 | | | 0 | . 0 | 92.00 |
| 0.00 09500 AMBULANCE SERVICES | 0.692252 | | | g same and an one | The second second second | |
| 00.00 Subtotal (see instructions) | 0.032232 | | C | 1 | *** | 95.00 |
| J1.00 Less PBP Clinic Lab. Services-Program | | U | 0 | 0 | 0 | 200.00 |
| Only Charges | | | 0 | 0 | | 201.00 |
| 02.00 Net Charges (line 200 +/- line 201) | | n | ^ | | | |
| | | O; | U | 0 | 0 | 202.00 |

0

202.00

| Health Financial Systems | PERRY COUNT | Y HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|--|--|---|---------------------------------------|---|--|-----------------------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA | L COSTS | | | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part I Date/Time Pre 5/30/2013 9: | epared: |
| Cost Center Description | Capital | Swing Bed | Reduced | Hospital Total Patient | PPS | 7 |
| | Related Cost (from Wkst. B, Part II, col. 26) | Adjustment | Capital Related Cost (col. 1 - col 2) | Days | 3 / col. 4) | |
| The state of the s | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS | | .r | ar en la la caractera | 27 | e a series | |
| 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 43.00 NURSERY 200.00 Total (lines 30-199) | 434,062 36,613 5,868 476,543 | | 7 376,79 36,61 5,86 419.27 | 3 248 8 164 | 147.63 35.78 | 31.00 43.00 |
| Cost Center Description | Inpatient Program days | Inpatient Program Capital Cost (col. 5 x col. 6) 7.00 | | 4,300 | | 200.00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | 0.00 | 7.00 | J | Mark Mark Control of the Control | the second of | |
| 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 43.00 NURSERY 200.00 Total (lines 30-199) | 382 11 97 490 | 1,624 3,471 | ! | | | 30.00 31.00 43.00 200.00 |

| ealth Financial Systems | PERRY COUNT | | | | u of Form CMS- | 2552-1 |
|--|--|---|-----------------------|---|---|----------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT | TAL COSTS | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | | pared: 3 am |
| the country of the annual country of the country of | ALC: USE OF PROPERTY AND A SECOND PROPERTY A | Tit | le XIX | Hospital | PPS | |
| Cost Center Description | | Total Charges (from Wkst. C, Part I, col. 8) | to Charges | Program | Capital Costs (column 3 x column 4) | |
| | 26) | | vv. mornapionagrada s | | a policina in in | |
| The state of the s | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCILLARY SERVICE COST CENTERS | | | gr | 4, | | |
| 0.00 OPERATING ROOM | 103,246 | | | | 4,933 | 50.0 |
| 2.00 05200 DELIVERY ROOM & LABOR ROOM | 11,297 | 1 | | | 3,835 | 52.0 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 113,644 | , | | | 1,527 | 54.0 |
| 0.00 06000 LABORATORY | 36,178 | | | | 772 | 60.0 |
| 22.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 1,010 | , | | -, | 23 | 62.0 |
| 5.00 06500 RESPIRATORY THERAPY | 46,784 | | | | 2,241 | 65.0 |
| 6.00 06600 PHYSICAL THERAPY | 73,241 | | | 11,168 | 435 | 66.0 |
| 7.00 06700 OCCUPATIONAL THERAPY | 3,486 | | | -, | | 67.0 |
| 8.00 06800 SPEECH PATHOLOGY | 4,399 | | | , | 20 | 68.0 |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 6,224 | .,, | | | 250 | 71.0 |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENT | 367 | | | -: | 0 | 72.0 |
| 3.00 07300 DRUGS CHARGED TO PATIENTS | 33,321 | 12,685,879 | 0.00262 | 27 479,903 | 1,261 | 73.0 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 0.00 09000 CLINIC | 60,968 | | | ; | | 90.0 |
| 1.00 09100 EMERGENCY | 81,876 | | | | | |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 46,588 | 359,799 | 0.12948 | 12,635 | 1,636 | 92.0 |
| OTHER REIMBURSABLE COST CENTERS | 4-1 | | | | | |
| 5.00 09500 AMBULANCE SERVICES | | | | | | 95.0 |
| 200.00 Total (lines 50-199) | 622,629 | 59,056,611 | Ì | 1,658,524 | 17,761 | 200.0 |

| Health Financial Systems | PERRY COUNT | | | In Lie | u of Form CMS- | 2552-10 |
|--|---------------------|--|---------------------------------------|--|--|------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH | ER PASS THROUGH COS | | - | Period: From 01/01/2012 Fo 12/31/2012 | | epared: L3 am |
| Compared to the compared to th | | rapide to a secondary and a second account of the second | le XIX | Hospital | PPS | |
| Cost Center Description | - | Allied Health Cost | All Other Medical Education Cos | Swing-Bed Adjustment Amount (see instructions) | Total Costs (sum of cols. 1 through 3, minus col. 4) | |
| g to decrease the contract of | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | Made a | 1 |
| 30.00 03000 ADULTS & PEDIATRICS | 0 | 0 |) (| 0 | 0 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 0 |) (|) (|) | 0 | 31.00 |
| 43.00 04300 NURSERY | 0 |) (|) (|) | Ô | 43.00 |
| 200.00 Total (lines 30-199) | 0 |) c | |) | Õ | 200.00 |
| Cost Center Description | | Per Diem (col. | | Inpatient | | 200.00 |
| | Days | 5 ÷ col. 6) | Program Days | Program Pass-Through Cost (col. 7 x col. 8) | | |
| * * * * * * * * * * * * * * * * * * * | 6.00 | 7.00 | 8.00 | 9.00 | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | to compare and the | . 5.5 | | 1 |
| 30.00 03000 ADULTS & PEDIATRICS | 4,174 | 0.00 | 382 | 2 0 | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 248 | 0.00 | | - | | 31.00 |
| 43.00 04300 NURSERY | 164 | | | | | 43.00 |
| 200.00 Total (lines 30-199) | 4,586 | | 490 | 1 | | 200.00 |

| Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | PERRY COUNTY | | CCN: 151322 | Period: | w of Form CMS- Worksheet D | 2334-1 |
|--|--|-----------------|--|--|--|--------|
| THROUGH COSTS | O.MER TADO | · · · · · · · · | CCM. IJIJZZ | From 01/01/2012 | Part IV | |
| | | | | To 12/31/2012 | Date/Time Pre | pared: |
| | | T-1. | le XIX | | 5/30/2013 9:1 | .3 am |
| Cost Center Description | Non Dhysician N | | | Hospital | PPS | · · |
| cost center best therein | Non Physician N Anesthetist Cost | ursing school | Allied Healt | h All Other Medical Education Cost | Total Cost (sum of col 1 through col. 4) | |
| The state of the s | 1.00 | 2.00 | 3.00 | 4.00 | 5,00 | |
| ANCILLARY SERVICE COST CENTERS | er i i i i i i i i i i i i i i i i i i i | | eli comenzare e se cita di Sasti da dagangan | western and CTT | to the TANT on the | |
| 50.00 O5000 OPERATING ROOM | 0 | 0 |) | 0 | 0 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 |) | 0 | 0 | 52.00 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 0 | 0 |) | 0 | 0 | |
| 60.00 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 |) | 0 | 0 | 62.00 |
| 65.00 06500 RESPIRATORY THERAPY | 0 | 0 |) | 0 0 | 0 | 65.00 |
| 66.00 06600 PHYSICAL THERAPY | 0 | 0 |) | 0 0 | o | 66.00 |
| 67.00 06700 OCCUPATIONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 1 | 0 0 | Ō | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | • | 0 | 0 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90.00 09000 CLINIC | 0 | 0 | | 0 | 0 | 90.00 |
| 91.00 09100 EMERGENCY | 0 | 0 | | 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95.00 09500 AMBULANCE SERVICES | | | | | | 95.00 |
| 200.00 Total (lines 50-199) | 0 | 0 | | 0 | 0 | 200.00 |

| Health Financial Systems | PERRY COUNT | | | | u of Form CMS- | 2552-10 |
|--|---|---|---------|---|--|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS | ERVICE OTHER PAS | | | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Pre 5/30/2013 9:1 | |
| en de la companya de la companya de la companya de la companya de la companya de la companya de la companya de | 1.18g | | le XIX | Hospital | PPS | |
| Cost Center Description | Total Outpatient Cost (sum of col. 2, 3 and | Total Charges (from Wkst. C, Part I, col. 8) | | Ratio of Cost to Charges (col. 6 ÷ col. | Inpatient Program Charges | The same of the sa |
| | 4) 6,00 | 7.00 | 8.00 | 7) 9.00 | 10.00 | |
| ANCILLARY SERVICE COST CENTERS | | | J., | 2.00 | 10.00 | |
| 50.00 05000 OPERATING ROOM | 0 | 4,667,635 | 0.00000 | 0.000000 | 223,000 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 393,364 | | | 133,538 | |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 0 | 14,940,310 | | | 200.677 | |
| 60.00 06000 LABORATORY | 0 | 8,690,753 | 0.00000 | 0.000000 | 185.532 | |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 381,339 | 0.00000 | 0.000000 | 8,612 | |
| 65.00 06500 RESPIRATORY THERAPY | 0 | 3,370,974 | 0.00000 | 0.000000 | 161,498 | 65.00 |
| 66.00 06600 PHYSICAL THERAPY | 0 | 1,880,387 | 0.00000 | 0.000000 | 11,168 | 66.00 |
| 67.00 06700 OCCUPATIONAL THERAPY | 0 | 568,004 | 0.00000 | 0.000000 | 8,150 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 416,010 | | 0.000000 | 1,911 | 68.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 4,590,669 | | | 184,072 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 53,650 | | -, | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 12,685,879 | 0.00000 | 0.000000 | 479,903 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC | | | 1 | | | |
| 91.00 09100 EMERGENCY | 0 | , | | | 652 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0,0,.55 | | | 47,176 | |
| OTHER REIMBURSABLE COST CENTERS | | 359,799 | 0.00000 | 0.000000 | 12,635 | 92.00 |
| 95.00 09500 AMBULANCE SERVICES | 1 | | 1 | 1 1 | | 05.00 |
| 200.00 Total (lines 50-199) | 0 | 59,056,611 | | | 1 659 534 | 95.00 |
| | | 33,030,011 | 1 | 1 | 1,658,524 | 200.L |

| Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S | PERRY COUNTY | Browiden | CCN: 151322 | Period: | u of Form CMS | -2332-1 |
|--|--|----------------------------------|--|-----------------|--|---------|
| THROUGH COSTS | ERVICE OTHER PASS | Flovides | CCN: 131322 | From 01/01/2012 | Worksheet D Part IV | |
| | | | | To 12/31/2012 | Date/Time Pr | epared: |
| | | Ti | tle XIX | Hospital | 5/30/2013 9: | 13 am |
| Cost Center Description | Inpatient Program Pass-Through Costs (col. 8 × col. 10) | Outpatient Program Charges | Outpatient Program Pass-Through Costs (col. x col. 12) | 1 | PPS | |
| The state of the s | 11.00 | 12.00 | 13.00 | | | |
| ANCILLARY SERVICE COST CENTERS | on the same of the | | | | eta en la como de la composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della compositi | |
| 50.00 05000 OPERATING ROOM | 0 | |) | 0 | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | (|) | 0 | | 52.00 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 0 | (| | 0 | | 54.00 |
| 60.00 06000 LABORATORY | 0 | (|) | 0 | | 60.00 |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | (| | 0 | | 62.0 |
| 65.00 06500 RESPIRATORY THERAPY | 0 | (|) | 0 | | 65.00 |
| 66.00 06600 PHYSICAL THERAPY | 0 | (|) | 0 | | 66.00 |
| 67.00 06700 OCCUPATIONAL THERAPY | 0 | (|) | 0 | | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | C |) | 0 | | 68.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | C | | 0 | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | C |) | 0 | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | |) | 0 | | 73.00 |
| OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC | 1 11 | | 1 | | |] |
| 91.00 09100 EMERGENCY | 0 | C |) | 0 | | 90.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | Q | | 0 | | 91.00 |
| OTHER REIMBURSABLE COST CENTERS | | | ! | 0 | | 92.00 |
| 95.00 09500 AMBULANCE SERVICES | 1 7 | | 1 | 4 | | |
| 200.00 Total (lines 50-199) | | | J | | | 95.00 |
| | 0 | U | 1 | 0 | | 200.00 |

| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN | D VACCINE COST | Provider | CCN: 151322 | Period: | Worksheet D | |
|--|--------------------------------|----------------|--------------------|-----------------|---------------------------------------|--------|
| | | | | From 01/01/2012 | Part V | |
| | | | | To 12/31/2012 | | pared: |
| | | Tit | le XIX | Hospital | 5/30/2013 9:1 PPS | .5 am |
| The state of the s | | l | Charges | nospica. | Costs | 1 |
| Cost Center Description | Cost to Charge | PPS Reimbursed | | Cost | PPS Services | |
| | Ratio From | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | Worksheet C, | inst.) | Services | Services Not | | |
| | Part I, col. 9 | | Subject To | Subject To | | |
| | | | Ded. & Coins | | | |
| | 1 00 | 2 22 | (see inst.) | | No. 2 29 Care | |
| ANCILLARY SERVICE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 50.00 O5000 OPERATING ROOM | 0.308522 | | 450 42 | . e | ******* * | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0.308322 | | 458,43 | | 0 | |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 0.205868 | | , | | 0 | |
| 60.00 06000 LABORATORY | 0.243342 | | 1,501,80 829,76 | | 0 | |
| 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0.531656 | 1 - | 7,01 | | 0 | |
| 65.00 06500 RESPIRATORY THERAPY | 0.389758 | | 163,77 | | 0 | |
| 56.00 06600 PHYSICAL THERAPY | 0.417024 | - | 125,54 | | 0 | |
| 57.00 06700 OCCUPATIONAL THERAPY | 0.270796 | | 84,79 | | 0 | |
| 58.00 06800 SPEECH PATHOLOGY | 0.500630 | · · | 161,56 | | 0 | 1 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0.111142 | T | 392,07 | | 0 | 1 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 1.388071 | 0 | 332,07 | 0 0 | 0 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0.240044 | 0 | 945,42 | 7 0 | 0 | |
| OUTPATIENT SERVICE COST CENTERS | of a president of the state of | | | III | · · · · · · · · · · · · · · · · · · · | 73.00 |
| 00.00 09000 CLINIC | 1.569515 | 0 | 36,17 | 0 | Ó | 90.00 |
| 01.00 09100 EMERGENCY | 0.412742 | 0 | 1,108,52 | | ő | |
| 02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1.504988 | 0 | 27,54 | 4 0 | Ō | |
| OTHER REIMBURSABLE COST CENTERS | | | **** | | | |
| 95.00 09500 AMBULANCE SERVICES | 0.692252 | 0 | 106,98 | | | 95.00 |
| 200.00 Subtotal (see instructions) | | 0 | 6,045,18 | 2 0 | 0 | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program Only Charges | : | | | 0 0 | | 201.00 |
| 202.00 Net Charges (line 200 +/- line 201) | | 0 | 6,045,18 | 2 0 | • | 202.00 |

| Health Financial Systems | PERRY COUNT | | | In Lieu of Form CMS-25 | | |
|--|--|--|-----|---|-----|----------------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES | AND VACCINE COST | Provider C | | Period: From 01/01/2012 To 12/31/2012 | | red: |
| the control of the co | erry an arman | Title | XIX | Hospital | PPS | |
| Care Camera Barradada | Cos | The second secon | | | | |
| Cost Center Description | Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) | Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) | | | | |
| The state of the s | 6.00 | 7.00 | | | | |
| ANCILLARY SERVICE COST CENTERS | interior de la companya della companya della compan | garteles and an array garage | | | | |
| 50.00 05000 OPERATING ROOM | 141,437 | | | | 5 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 18,942 | 1 | | | 1 - | 52.0 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 309,173 | i i | | | | 54.0 |
| 60.00 06000 LABORATORY | 201,916 | | | | 1 | 60.00 |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65.00 06500 RESPIRATORY THERAPY | | 1 2 1 | | | · · | 62.00 |
| 66.00 06600 PHYSICAL THERAPY | 63,833 | | | | | 65.00 |
| 67.00 06700 OCCUPATIONAL THERAPY | 52,354 | | | | * | 56.0 |
| 68.00 06800 SPEECH PATHOLOGY | 22,961 80,884 | | | | | 57.0 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 43,576 | | | | | 58.0 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 43,370 | | | | | 71.00 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 226.944 | 9 | | | | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | L | | | | 3.00 |
| 90.00 09000 CLINIC | 56.769 | 0 | | | · | 90.00 |
| 91.00 09100 EMERGENCY | 457,534 | - 1 | | | 1 ' | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 41,453 | | | | 1 - | 92.0 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95.00 09500 AMBULANCE SERVICES | 74,059 | | | | g | 95.00 |
| 200.00 Subtotal (see instructions) | 1,795,565 | 0 | | | | 00.0 |
| 201.00 Less PBP Clinic Lab. Services-Progra Only Charges | um O | | | | 1 | 01.0 |
| 202.00 Net Charges (line 200 +/- line 201) | 1,795,565 | 0 | | | 20 | 02.0 |
| | | | | | | |

| UMPU | TATION OF INPATIENT OPERATING COST Prov | vider CCN: 151322 | Period: From 01/01/2012 | Worksheet D-1 | |
|------|---|-----------------------------------|--|--------------------------------|----------|
| | | | To 12/31/2012 | Date/Time Pre 5/30/2013 9:1 | |
| | Cost Center Description | Title XVIII | Hospital | Cost | |
| | PART I - ALL PROVIDER COMPONENTS | | and an appearance of the constant of the const | 1.00 | |
| 00 | INPATIENT DAYS | | | | - |
| .00 | Inpatient days (including private room days and swing-bed days, excl Inpatient days (including private room days, excluding swing-bed and | uding newborn) | | 4,836 | 1 |
| .00 | Private room days (excluding swing-bed and observation bed days). If do not complete this line. | newborn days) you have only pr | ivate room days, | 4,174 0 | 1 |
| .00 | Semi-private room days (excluding swing-bed and observation bed days |) | | 3,726 | 4. |
| .00 | Total swing-bed SNF type inpatient days (including private room days reporting period |) through Decembe | | 631 | 1 |
| .00 | Total swing-bed SNF type inpatient days (including private room days reporting period (if calendar year, enter 0 on this line) | | | 0 | 6. |
| .00 | Total swing-bed NF type inpatient days (including private room days) reporting period | | | 31 | 7 |
| .00 | Total swing-bed NF type inpatient days (including private room days) reporting period (if calendar year, enter 0 on this line) | | | 0 | 8. |
| .00 | Total inpatient days including private room days applicable to the P newborn days) | | | 2,459 | 9. |
| 0.00 | through December 31 of the cost reporting period (see instructions) | | | 631 | 10. |
| .00 | December 31 of the cost reporting period (if calendar year, enter 0 | on this line) | | 0 | 11 |
| | Swing-bed NF type inpatient days applicable to titles V or XIX only through December 31 of the cost reporting period | | | 0 | 12 |
| | Swing-bed NF type inpatient days applicable to titles V or XIX only after December 31 of the cost reporting period (if calendar year, en | ter O on this lin | e) | 0 | 13 |
| 00. | Medically necessary private room days applicable to the Program (exc Total nursery days (title V or XIX only) | luding swing-bed | days) | 0 | 1 |
| .00 | Nursery days (title v or xix only) SWING BED ADJUSTMENT | 1.00 | | 0 | 15 16 |
| .00 | Medicare rate for swing-bed SNF services applicable to services thro reporting period | ugh December 31 o | f the cost | | 17 |
| .00 | Medicare rate for swing-bed SNF services applicable to services afte reporting period | r December 31 of | the cost | | 18 |
| | Medicaid rate for swing-bed NF services applicable to services througeneouting period | | | 132.00 | 19 |
| | Medicaid rate for swing-bed NF services applicable to services after reporting period | December 31 of t | he cost | 132.00 | 20 |
| .00 | Total general inpatient routine service cost (see instructions) | | ; | 5,811,846 | 21 |
| | Swing-bed cost applicable to SNF type services through December 31 of x line 17) | | | | 22 |
| | Swing-bed cost applicable to SNF type services after December 31 of x line 18) | | | | 23 |
| | Swing-bed cost applicable to NF type services through December 31 of 7 x line 19) | | | 4,092 | 24 |
| | Swing-bed cost applicable to NF type services after December 31 of the x line 20) | ne cost reporting | period (line 8 | | 25 |
| .00 | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 2) | 1 m4m.m 34 262 | | 766,775 | 26 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | i minus iine 26) | | 5,045,071 | 27. |
| 00 | General inpatient routine service charges (excluding swing-bed charge | es) | 1 | 3,365,928 | 28 |
| 00 | Private room charges (excluding swing-bed charges) | , | | | 29 |
| 00 | Semi-private room charges (excluding swing-bed charges) | | | 3,365,928 | |
| 00 | General inpatient routine service cost/charge ratio (line 27 ÷ line 2 | 28) | | 1.498865 | |
| 00 | Average private room per diem charge (line 29 ÷ line 3) | | | 0.00 | |
| UU | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 903.36 | |
| w | Average per diem private room charge differential (line 32 minus line | e 33)(see instruc | tions) | 0.00 | |
| OC. | Average per diem private room cost differential (line 34 x line 31) | | | 0.00 | |
| 00 | Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room in the 36) | | fferential (line | 0 5,045,071 | 36 37 |
| | PART II - HOSPITAL AND SURPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | 4 A - 4 - 4 | | | |
| .00 | Adjusted general inpatient routine service cost per diem (see instruc | tions) | | 1 200 60 | 2.0 |
| 00 | Program general inpatient routine service cost (line 9 x line 38) | | | 1,208.69 2,972,169 | |
| | | | 1 | ~, J/ C, 109} | 33. |
| .00 | Medically necessary private room cost applicable to the Program (line Total Program general inpatient routine service cost (line 39 + line | 2 14 x line 35) | | | 40. |

| COMPU | n Financial Systems TATION OF INPATIENT OPERATING COST | PERRY COUNT | | ider | CCN: 151322 | Period: | worksheet D-1 | |
|-----------|--|----------------------------------|----------------|--------|-----------------|-----------------|--|------------|
| _ | | | FIOV | , uci | | From 01/01/2012 | | |
| | | | | | | To 12/31/2012 | Date/Time Pre 5/30/2013 9:1 | |
| | | | | Titl | e XVIII | Hospital | 7/30/2013 9.1 Cost | וווא כו |
| | Cost Center Description | Total | Total | | Average Per | Program Days | Program Cost | |
| | | Inpatient Cost | Inpatient | Days | | ÷ | (col. 3 x col. | |
| | | 1.00 | 2.00 | | col. 2) 3.00 | 4.00 | 4) 5.00 | |
| 2.00 | NURSERY (title V & XIX only) | 2.00 |) | . 0 | 0.0 | | for the second of the second o | 42. |
| | Intensive Care Type Inpatient Hospital Units | | · | | | 7) | <u> </u> | 72 |
| | INTENSIVE CARE UNIT | 587,017 | 7 | 248 | 2,367.0 | 0 168 | 397,656 | 43 |
| | CORONARY CARE UNIT | | | | | | | 44 |
| | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT | | | | | | | 45 |
| 7.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | | 46 |
| | Cost Center Description | | 1 | ! | | | | 47 |
| | | | | | | * | 1.00 | |
| 3.00 | Program inpatient ancillary service cost (Wks | st. D-3, col. | 3, line 20 |)) | | | 2,146,830 | 48 |
| 9.00 | Total Program inpatient costs (sum of lines | 11 through 48) | (see instr | uctio | ns) | | 5,516,655 | |
| 00 | PASS THROUGH COST ADJUSTMENTS | | | . c | | ^ | | |
| 0.00 | Pass through costs applicable to Program inpa | itient routine | services | trom | Wkst. D, sum | of Parts I and | 0 | 50 |
| 1.00 | Pass through costs applicable to Program inpa | atient ancilla | rv service | (fr | om Wkst D si | m of Parts TT | ^ | 51 |
| | and iv) | | , ==: | | | OI (WILES IT | U | 11 |
| 2.00 | Total Program excludable cost (sum of lines | 0 and 51) | | | | | . 0 | 52 |
| 3.00 | Total Program inpatient operating cost excludemedical education costs (line 49 minus line 5 | ling capital re | elated, no | 1-phy: | sician anesth | etist, and | 0 | 53 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | | | | | | |
| 4.00 | Program discharges | | | | | | | - 4 |
| 5.00 | Target amount per discharge | | | | | | 0.00 | 54 |
| 5.00 | Target amount (line 54 x line 55) | | | | | | | 56 |
| 7.00 | Difference between adjusted inpatient operati | ng cost and ta | arget amou | it (1: | ine 56 minus i | line 53) | | 57 |
| .00 | Bonus payment (see instructions) | | | | | | 0 | 58 |
| . 00 | Lesser of lines 53/54 or 55 from the cost repmarket basket | orting period | ending 199 | 96, uj | odated and cor | npounded by the | 0.00 | 59 |
| 00.0 | Lesser of lines 53/54 or 55 from prior year of | ost renort ur | ndated by | he m | arket backet | | 0.00 | - |
| 1.00 | IT line 33/34 is less than the lower of lines | 55. 59 or 60 | enter the | 10556 | er of 50% of 1 | the amount by | 0.00 | 1 |
| | which operating costs (line 53) are less than | expected cost | ts (lines ! | 4 x (| 50), or 1% of | the target | U | 0.1 |
| | amount (line bb). Otherwise enter zero (see i | nstructions) | | | | , | | 1 |
| 2.00 | Relief payment (see instructions) | | | | | | 0 | |
| | Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST | nt (see instru | ictions) | | | | 0 | 63 |
| .00 | Medicare swing-bed SNF inpatient routine cost | s through Dece | mher 31 of | the | cost reporti | on pariod (Soc | 762 603 | C.A |
| | INSTRUCTIONS)(TITLE XVIII only) | | | | | | 762,683 | 64 |
| 5.00 | Medicare swing-bed SNF inpatient routine cost | s after Decemb | er 31 of t | he co | st reporting | period (See | 0 | 65 |
| | instructions)(title XVIII only) | | | | | | · | |
| | Total Medicare swing-bed SNF inpatient routin CAH (see instructions) | e costs (line | 64 plus li | ne 65 | 5)(title XVIII | only). For | 762,683 | 66 |
| 7.00 | Title V or XIX sting-bed NF inpatient routine | costs through | Docombon | 21 04 | the cost year | | _ | |
| | (line 12 x line 19) | | | | | | U | 67 |
| 3.00 | Title V or XIX swing-bed NF inpatient routine | costs after D | ecember 31 | of t | he cost repor | ting period | n | 68 |
| | (11ne 13 x 11ne 20) | | | | | g par | Ü | 00 |
| 0.00 | Total title V or XIX swing-bed NF inpatient r | outine costs (| line 67 + | line | 68) | | 0 | 69 |
| 0.00 | PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili | RSING FACILITY | , AND ICF/ | MR ON | LY | | | |
| .00 | Adjusted general inpatient routine service co | ty/ICF/MR rout st nor diam (1 | ine servic | e cos | it (line 37) | , | | 70. |
| .00 | Program routine service cost (line 9 x line 7 | ac per diem (i | ine 70 + 1 | me z | .) | | | 71. |
| .00 | Medically necessary private room cost applica | ble to Program | (line 14 | x lin | e 35) | | | 72 73 |
| .00 | lotal Program general inpatient routine servi | ce costs (line | 72 ± 1 ine | 733 | | | | 74. |
| .00 | Capital-related cost allocated to inpatient r | outine service | costs (fr | om Wo | rksheet B, Pa | rt II, column | | 75 |
| | 26, line 45) Per diem capital-related costs (line 75 ÷ lin | | | | | | | |
| .00 | Program capital-related costs (line 9 x line | 76) | | | | | | 76. |
| .00 | Inpatient routine service cost (line 74 minus | line 77) | | | | | | 77. |
| .00 | Aggregate charges to beneficiaries for excess | costs (from n | rovider re | cords |) | | i | 78. 79. |
| .00 | Total Program routine service costs for compa | rison to the c | ost limita | tion | (line 78 minu | s line 79) | | 80 |
| .00 | inpatient routine service cost per diem limit: | ation | | | | | 1 | 81. |
| 00. 00 | Inpatient routine service cost limitation (li | ne 9 x line 81 |) | | | | | 82. |
| .00 | Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins | ee instruction | s) | | | | | 83. |
| .00 | Utilization review - physician compensation (| tructions) | nc) | | | | | 84. |
| .00 | Total Program inpatient operating costs (sum) | of lines 83 th | rough 25) | | | | | 85. |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS | THROUGH COST | | | | | | 86. |
| .00 | Total observation bed days (see instructions) | | | | | | 448 | 87 |
| | Adjusted general impations would | | | | | | 770 | 0/. |
| .00 ⊴ | Adjusted general inpatient routine cost per dobservation bed cost (line 87 x line 88) (see | iem (line 27 ÷ | line 2) | | | | 1,208.69 | 88. |

| Health Financial Systems | PERRY COUN | ITY HOSPITAL | In Lieu of Form CMS-2552-1 | | | |
|--|------------|-----------------------------------|--|--|--|----------------------------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider | | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | pared: |
| The same of the sa | | Titl | e XVIII | Hospital | Cost | |
| Cost Center Description | Cost | Routine Cost (from line 27) | column 1 ÷ column 2 | Total Observation Bed Cost (from line 89) | Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) | |
| The second secon | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 90.00 Capital-related cost 91.00 Nursing School cost 92.00 Allied health cost 93.00 All other Medical Education | COST | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0.00000 0.00000 0.00000 0.00000 | 0 0 | 0 0 0 0 | 90.00 91.00 92.00 93.00 |

| COMP | TATION OF INPATIENT OPERATING COST PERRY COUNTY HO | Provider CCN: 151322 | Period: | u of Form CMS- Worksheet D-1 | |
|--------------|--|--|--|--|-----------|
| | | | From 01/01/2012 To 12/31/2012 | | |
| · Agent of · | Cost Center Description | Title XIX | Hospital | 5/30/2013 9:1 PPS | .3 am |
| | PART I - ALL PROVIDER COMPONENTS | The state of the s | | 1.00 | |
| | INPATIENT DAYS | and continued to the second and before a 111 months of the second and the second | State Million and the second of the second o | The same of the sa | |
| 1.00 | | , excluding newborn) | | 4,836 | 1. |
| 2.00 | Inpatient days (including private room days, excluding swing-h | ed and newborn days) | | 4,174 | |
| .00 | Private room days (excluding swing-bed and observation bed day do not complete this line. | s). If you have only pr | ivate room days, | . 0 | 1 |
| .00 | Semi-private room days (excluding swing-bed and observation be | d days) | | | |
| .00 | Total swing-bed SNF type inpatient days (including private roo | u uays) m days) through Decembe | r 31 of the cost | 3,726 | 1 |
| | reporting period | | | 631 | 5. |
| .00 | Total swing-bed SNF type inpatient days (including private roof | m days) after December | 31 of the cost | 0 | 6. |
| .00 | reporting period (II Calendar Vear, enter () on this line) | | 1 | | |
| | Total swing-bed NF type inpatient days (including private room reporting period | days) through December | 31 of the cost | 31 | 7. |
| 3.00 | Total swing-bed NF type inpatient days (including private room | days) after December 3 | 1 of the cost | 0 | |
| | reporting period (IT Calendar Vear, enter () on this line) | | | U | 8. |
| .00 | Total inpatient days including private room days applicable to newborn days) | the Program (excluding | swing-bed and | 382 | 9. |
| 0.00 | Swing-bed SNF type inpatient days applicable to title XVIII on | | i | | |
| | Circular December of the Cost reporting period (see instruct- | ionel | | 0 | 10. |
| 1.00 | SWING-Ded SNF type inpatient days applicable to title system on | lu (includina anivata a | nom dave) after | 0 | -1-1 |
| | December of the Cost Leboring Deving (it calcular Mose And | ton () on this limi | | U | 11. |
| 2.00 | Swing-bed NF type inpatient days applicable to titles V or viv | only (including private | e room days) | 31 | 12. |
| | through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period | | | | |
| | with pecelines of the cost tenotified belief it calendar vo- | in onton O on this lie. | - 1 | 0 | 13. |
| 4.00 | recurred by necessary private room days applicable to the program | n (excluding swing-hed | dave) | 0 | 14 |
| ,,,,,, | incal nursery days (title v or xtx only) | excidency swing bed | 10x3) | 164 | 14. 15 |
| 0.00 | Nursery days (title V or XIX only) | | | | 16. |
| 7.00 | SWING BED ADJUSTMENT Medicare rate for swing-hod SNF commission and in the | and the second second | | | |
| | Medicare rate for swing-bed SNF services applicable to services reporting period | s through December 31 of | f the cost | | 17. |
| 8.00 | Medicare rate for swing-bed SNF services applicable to services | after December 31 of a | the cost | | |
| | | | | | 18. |
| 9.00 | Medicaid rate for swing-bed NF services applicable to services reporting period | through December 31 of | the cost | 132.00 | 19. |
| | Medicaid rate for swing-bed NF services applicable to services | | | | |
| | reporting period | | ne cost | 132.00 | 20. |
| 1.00 | Total general inpatient routine service cost (see instructions) | | | 5,811,846 | 21 |
| 2.00 | SWING-Ded Cost applicable to SNF type services through December | 31 of the cost reporti | ng period (line | | 22. |
| | | | | | ~~, |
| | Swing-bed cost applicable to SNF type services after December 3 x line 18) | 1 of the cost reporting | period (line 6 | 0 | 23. |
| 4.00 | Swing-bed cost applicable to NF type services through December 7 x line 19) | 31 of the cost managed | | | |
| | | | | 4,092 | 24. |
| 5.00 | Swing-bed cost applicable to NF type services after December 31 x line 20) | of the cost reporting | period (line 8 | 0 | 25.6 |
| | Total swing-bed cost (see instructions) | . 2 | , | J | 23. |
| 7.00 | General inpatient routine service cost net of swing-bed cost (1 | dan 31 mdu - 31 - 305 | | 766,775 | |
| | PRIVALE KUUM DIFFERENTIAL ADJUSTMENT | | | 5,045,071 | 27.0 |
| .00 | General inpatient routine service charges (excluding swing had | charges) | | 2 265 020 | 20. |
| .00 | Private room charges (excluding swing-hed charges) | g -, | | 3,365,928 | 29.0 |
| טט. חח | Semi-private room charges (excluding swing-bed charges) | | | 3,365,928 | |
| .00 | General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) | line 28) | | 1.498865 | |
| .00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 | |
| ·UU | Average per diem private room charge differential (line 32 minus | s line 33)(see instruct | ions) | 903.36 | |
| | AVENUE DEL UTEM DELVATO FOOR COST AITTOPONTIAL (Lina 24 y 1ima | 31) | 10113) | 0.00 | |
| .00 | Private room cost differential adjustment (line 3 v line 35) | | | 0.00 | 36.0 |
| .00 | General inpatient routine service cost net of swing-bed cost and 27 minus line 36) | d private room cost dif | ferential (line: | 5,045,071 | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | , -, | |
| | PROGRAM INPATIENT OPERATING COST REFORE DASS THROUGH COST ADDITION | MENTS | | | |
| .00 | Adjusted general inpatient routine service cost per diem (see in | nctructions) | en a de se en en en en en en en en en en en en en | 1 209 62 | 20 - |
| .00 | rivgiam general inpatient routine service cost (line o v line 2) | D1 | | 1,208.69 461,720 | |
| 1 11 1 | Medically necessary private room cost applicable to the program | (73 - 44 - 71 - 75) | • | | |
| 00 | Total Program general inpatient routine service cost (line 39 + | (Time 14 X Time 33) | | n: | 40.0 |

| | TATION OF INPATIENT OPERATING COST | | Prov | luer (| CCN: 151322 | Period: | Worksheet D-1 | L |
|-----------|---|--|--------------------|--------|---|---|------------------------------------|------------|
| ********* | | | | | | From 01/01/201 To 12/31/201 | | |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient | | e XIX Average Per Diem (col. 1 col. 2) | | PPS Program Cost (col. 3 x col. 4) | |
| 3 00 | MINCERY CHALLE WE NEW TO | 1.00 | 2.00 | | 3.00 | 4.00 | 5.00 | |
| 2.00 | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units | 60,834 | 1 | 164 | 370. | 94 9 | 7 35,981 | 42. |
| 3.00 | INTENSIVE CARE UNIT | 587,017 | | 248 | 2,367. | 00 1 | 1 26,037 | 43. |
| | CORONARY CARE UNIT | | | - 10 | _,,,,,, | - | 20,03, | 44. |
| | BURN INTENSIVE CARE UNIT | | | | | | | 45. |
| | SURGICAL INTENSIVE CARE UNIT | | | | | | | 46. |
| 7.00 | OTHER SPECIAL CARE (SPECIFY) Cost Center Description | | | | | | | 47. |
| | cost center bescription | | | | | | 1.00 | |
| 8.00 | Program inpatient ancillary service cost (Wk | st. D-3, col. 3 | 3, line 200 |)) | | | 432,184 | 48. |
| 9.00 | Total Program inpatient costs (sum of lines | 11 through 48) | (see instr | uction | is) | | 955,922 | |
| | PASS THROUGH COST ADJUSTMENTS | | | | | | | |
| 0.00 | Pass through costs applicable to Program inpa | atient routine | services | (from | Wkst. D, su | n of Parts I an | 39,578 | 50. |
| 1.00 | Pass through costs applicable to Program inpa | atient ancilla | rv sarvica | : (fro | m wket D | cum of Dante II | 17,761 | E1 |
| | and IV) | | y Service. | . (110 | m wkst. D, | Julii Ol Falles II | 17,701 | |
| 2.00 | Total Program excludable cost (sum of lines | 0 and 51) | | | | | 57,339 | 52. |
| 3.00 | Total Program inpatient operating cost excluding | ding capital re | elated, nom | 1-phys | ician anest | netist, and | 898,583 | 53. |
| | medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION | (2) | | | | | | |
| 4.00 | Program discharges | The state of the s | | | | | | 54. |
| 5.00 | Target amount per discharge | | | | | | | 55. |
| 6.00 | Target amount (line 54 x line 55) | | | | | | | 56. |
| 7.00 | Difference between adjusted inpatient operations payment (see instructions) | ing cost and ta | arget amou | 1t (1i | ne 56 minus | line 53) | | 57. |
| 9.00 | Lesser of lines 53/54 or 55 from the cost rep | orting paried | andina 100 | 16 | datad and c | manuad by the | . 0 | , |
| | market basket | | | | | impounded by the | . 0.00 | 59. |
| 0.00 | Lesser of lines 53/54 or 55 from prior year | ost report, up | dated by 1 | the ma | rket basket | | 0.00 | 60. |
| 1.00 | If line 53/54 is less than the lower of lines which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see | 5 55, 59 or 60 Dexpected cost | enter the | lesse | r of 50% of | the amount by F the target | 0 | 61. |
| 2.00 | Relief payment (see instructions) | instructions) | | | | | 0 | 62. |
| 3.00 | Allowable Inpatient cost plus incentive payme | nt (see instru | ctions) | | | | 1 0 | 1 |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | - | |
| 4.00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) | s through Dece | ember 31 of | the | cost report | ing period (See | 0 | 64. |
| 5.00 | Medicare swing-bed SNF inpatient routine cost | s after Decemb | er 31 of 1 | he co | st renortin | narind (See | 0 | 65. |
| | instructions)(title XVIII only) | | | | | | 0 | 05. |
| 6.00 | Total Medicare swing-bed SNF inpatient routing | e costs (line | 64 plus 11 | ne 65 |)(title XVI: | II only). For | 0 | 66. |
| 7 00 | CAH (see instructions) | | | 24 | | | | |
| 7,00 | Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) | costs through | December | 31 of | the cost re | eporting period | 4,092 | 67. |
| 8.00 | Title V or XIX swing-bed NF inpatient routine | costs after D | ecember 31 | oft | he cost reno | rting period | 0 | 68. |
| | (line 13 x line 20) | | • | | | remg per rou | | 00. |
| 9.00 | Total title V or XIX swing-bed NF inpatient r | outine costs (| line 67 + | line | 68) | | 4,092 | 69. |
| 0 00 | PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili | RSING FACILITY | , AND ICF/ | MR ON | LY | | | |
| 1.00 | Adjusted general inpatient routine service co | ty/ICF/MK rout st ner diem (1 | ine servic | e cos | t (11ne 3/) | | | 70. |
| 2.00 | Program routine service cost (line 9 x line 7 | 1) | | | | | | 71. |
| 3.00 | Medically necessary private room cost applica | ble to Program | (line 14 | x lin | e 35) | | | 73. |
| 4.00 | Total Program general inpatient routine servi | ce costs (line | 72 + line | 73) | | | | 74. |
| 5.00 | Capital-related cost allocated to inpatient r 26, line 45) | outine service | costs (fr | om Wo | rksheet B, F | art II, column | | 75. |
| 6.00 | Per diem capital-related costs (line 75 ÷ lin | e 2) | | | | | | 70 |
| 7.00 | Program capital-related costs (line 9 x line | 76) | | | | | | 76. 77. |
| 3.00 | Inpatient routine service cost (line 74 minus | line 77) | | | | | | 78. |
| 9.00 | Aggregate charges to beneficiaries for excess | costs (from p | rovider re | cords |) | | | 79. |
| .00 | Total Program routine service costs for compa Inpatient routine service cost per diem limit | rison to the c | ost limita | tion | (line 78 mir | us line 79) | | 80. |
| .00 | Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li | ation ne 9 v line 21 | ` | | | | | 81. |
| 3.00 | Reasonable inpatient routine service costs (s | ee instruction | , s) | | | | | 82. 83. |
| 1.00 | Program inpatient ancillary services (see ins | tructions) | | | | | | 84. |
| 5.00 | Utilization review - physician compensation (| see instructio | ns) | | | | | 85. |
| 0.00 | Total Program inpatient operating costs (sum | of lines 83 th | rough 85) | | | | 1 | 86. |
| 7.00 | PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions) | IHROUGH COST | | | | *************************************** | | - |
| 0 00 | Adjusted general inpatient routine cost per d | iem (line 27 : | line 2) | | | | 1,208.69 | 87. |
| 0.00 | Observation bed cost (line 87 x line 88) (see | TEM (TIME Z/ ~ | 11110 41 | | | | | |

| Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST | PERRY COUNT | | 1 | In Lie Period: From 01/01/2012 To 12/31/2012 | Date/Time Pre | pared: |
|---|----------------------------------|--|---------|---|---|--|
| Cost Center Description | Cost | Tit Routine Cost (from line 27) | | line 89) | (col. 3 x col. 4) (see | And the second s |
| 90.00 Capital-related cost 91.00 Nursing School cost 92.00 Allied health cost 93.00 All other Medical Education | 1.00 OST 434,062 0 0 | 2.00 5,045,071 5,045,071 5,045,071 5,045,071 | 0.00000 | 4.00 7 541,493 0 541,493 541,493 | 1nstructions) 5.00 46,588 0 0 | 91.00 92.00 |

| | inancial Systems | PERRY COUNTY HOSPITAL | | | u of Form CMS- | |
|--|---|----------------------------|----------------------------|---|---|--------|
| INPATIEN | T ANCILLARY SERVICE COST APPORTIONMENT | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 Date/Time Pre 5/30/2013 9:1 | pared: |
| | | Tit | e XVIII | Hospital | Cost | |
| THE COMMENT AND ADDRESS ASSESSMENT ASSESSMEN | Cost Center Description | | Ratio of Cos To Charges | Program | Inpatient Program Costs (col. 1 x col. | |
| | | | 1.00 | 2.00 | 2) 3.00 | |
| IN | PATIENT ROUTINE SERVICE COST CENTERS | | | | The Contract of the Contract | f |
| 30.00 03 | 3000 ADULTS & PEDIATRICS | | | 2,165,316 | | 30.00 |
| 31.00 03 | 3100 INTENSIVE CARE UNIT | | | 302,232 | | 31.00 |
| Section Section | 1300 NURSERY | | | | | 43.00 |
| | CILLARY SERVICE COST CENTERS | | | | | ĺ |
| | 0000 OPERATING ROOM | | 0.3085 | | 53,411 | 50.00 |
| | 5200 DELIVERY ROOM & LABOR ROOM | | 0.1977 | 31. 0 | 0 | 52.00 |
| | 7400 RADIOLOGY-DIAGNOSTIC | | 0.2058 | 862,980 | 177,660 | 54.00 |
| | 5000 LABORATORY | • | 0.2433 | 1,327,946 | 323,145 | 60.00 |
| | 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS | | 0.5316 | 116,962 | 62,184 | 62.00 |
| | 5500 RESPIRATORY THERAPY | | 0.3897 | 1,222,088 | 476,319 | 65.00 |
| | 6600 PHYSICAL THERAPY | | 0.4170 | | | |
| | 0700 OCCUPATIONAL THERAPY | | 0.2707 | | | 67.00 |
| | 5800 SPEECH PATHOLOGY | | 0.5006 | | | 68.00 |
| 1.00 07 | 100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.1111 | | 123,136 | 71.00 |
| | 7200 IMPL. DEV. CHARGED TO PATIENT | | 1.3880 | | - | 72.00 |
| | 300 DRUGS CHARGED TO PATIENTS | | 0.2400 | 3,268,489 | 784,581 | 73.00 |
| | TPATIENT SERVICE COST CENTERS | | | 9 | | |
| 5 | 0000 CLINIC | | 1.5695 | | | 90.00 |
| | 100 EMERGENCY | | 0.4127 | | , | 91.00 |
| | 200 OBSERVATION BEDS (NON-DISTINCT PART) | | 1.5049 | 38 0 | 0 | 92.00 |
| | HER REIMBURSABLE COST CENTERS | | 1 | | | |
| | 0500 AMBULANCE SERVICES | | | | | 95.00 |
| 00.00 | Total (sum of lines 50-94 and 96-98) | | | 8,452,463 | 2,146,830 | 3 |
| 01.00 | Less PBP Clinic Laboratory Services-Progr | ram only charges (line 61) | | 0 | | 201.00 |
| 4.00 | Net Charges (line 200 minus line 201) | | 1 | 8.452.463 | | 202.0 |

| Health Financial Systems | PERRY COUNTY HOSPITAL | to the second second second | | u of Form CMS- | 2552-10 |
|--|---|-----------------------------|-----------------------------------|---|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | · | CCN: 151322 | From 01/01/2012 | Worksheet D-3 | |
| | | | то 12/31/2012 | Date/Time Pre 5/30/2013 9:1 | |
| The state of the s | | | Swing Beds - SNF | Cost | |
| Cost Center Description | | Ratio of Cos To Charges | t Inpatient Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
| the second secon | PRODUCTION OF THE STATE OF THE | 1.00 | 2.00 | 3.00 | 1 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30.00 03000 ADULTS & PEDIATRICS | | | 0 | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | 0 | | 31.00 |
| 43.00 04300 NURSERY | | 1 | . I was a second | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | |
| 50.00 05000 OPERATING ROOM | | 0.30852 | | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0.19778 | | • | 52.00 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC 60.00 06000 LABORATORY | | 0.20586 | | , | 54.00 |
| | | 0.24334 | | | 60.00 |
| 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 55.00 06500 RESPIRATORY THERAPY | | 0.53165 | | | 62.00 |
| 66.00 06600 PHYSICAL THERAPY | | 0.38975 | | , | |
| 57.00 06700 OCCUPATIONAL THERAPY | | 0.41702 | | | |
| 58.00 06800 SPEECH PATHOLOGY | | 0.27079 | | | 67.00 |
| | | 0.50063 | | | 68.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.11114 | | 13,354 | |
| 72.00 07200 IMPL. DEV, CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS | | 1.38807 | -1 | 0 | |
| OUTPATIENT SERVICE COST CENTERS | | 0.24004 | 4 424,443 | 101,885 | 73.00 |
| 90.00 09000 CLINIC | | 1 5005 | iet at | | |
| 91.00 09100 EMERGENCY | | 1.56951 | , | - | , |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0.41274 | | 0 | , |
| OTHER REIMBURSABLE COST CENTERS | | 1.50498 | 0 | 0 | 92.00 |
| 95.00 09500 AMBULANCE SERVICES | | 1 | | | |
| 200.00 Total (sum of lines 50-94 and 96-98) | | | 077 470 | 252 45 | 95.00 |
| 201.00 Less PBP Clinic Laboratory Services-P | magnam anly shares (3in- 61) | | 973,470 | 260,495 | |
| 202.00 Net Charges (line 200 minus line 201) | rogram only charges (line 61) | | 072 | | 201.00 |
| - out of the charges (Time 200 minus Time 201) | | | 973,470 | | 202.00 |

| Health Financial Systems PERRY COUNTY | HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|--|-------------|----------------------------|---|---|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | pared: |
| Cost Center Description | Tit | Ratio of Cos To Charges | Program | PPS Inpatient Program Costs (col. 1 x col. 2) | |
| A TO BE A STANDARD CONTRACT OF THE STANDARD CO | | 1.00 | 2.00 | 3.00 | 1 |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS | | | | | |
| 31.00 03100 INTENSIVE CARE UNIT | | | 286,991 | | 30.00 |
| 43.00 04300 NURSERY | | | 47,689 | | 31.00 |
| ANCILLARY SERVICE COST CENTERS | | 1 | 0 | | 43.00 |
| 50.00 O5000 OPERATING ROOM | | 0.200 | 22 22 | | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0.30852 | | , | |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | | 0.19778 | | 26,411 | , |
| 50.00 06000 LABORATORY | | 0.20586 | | 41,313 | |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | | 0.24334 | | 45,148 | |
| 55.00 06500 RESPIRATORY THERAPY | | 0.3316 | - , | 4,579 | |
| 56.00 06600 PHYSICAL THERAPY | | 0.3897 | | 62,945 | |
| 57.00 06700 OCCUPATIONAL THERAPY | | 0.27079 | | 4,657 | |
| 58.00 06800 SPEECH PATHOLOGY | | 0.50063 | | 2,207 957 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.11114 | -, | 20,458 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 1.38807 | | 20,438 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0.24004 | | • | |
| OUTPATIENT SERVICE COST CENTERS | | , 0,2,100 | 112,203 | 173,130 | 73.00 |
| 90.00 09000 CLINIC | | 1.56951 | 652 | 1.023 | 90.00 |
| 91.00 09100 EMERGENCY | | 0.41274 | | 19,472 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 1.50498 | | | |
| OTHER REIMBURSABLE COST CENTERS | | | · | 25,010 | 52.00 |
| 95.00 09500 AMBULANCE SERVICES | | | | | 95.00 |
| 200.00 Total (sum of lines 50-94 and 96-98) | | | 1,658,524 | 432,184 | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charge | s (line 61) | | 0 | • | 201.00 |
| 202.00 Net Charges (line 200 minus line 201) | • | | 1,658,524 | | 202.00 |

| CALCU | 1 Financial Systems PERRY COUNTY LATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151322 | Period: | u of Form CMS- Worksheet E | |
|----------------|--|--|--|-------------------------------|--------|
| | | | From 01/01/2012 To 12/31/2012 | Part B Date/Time Pre | pared: |
| | | Title XVIII | | 5/30/2013 9:1 | 3 am |
| ***** | and the same of th | i itte valit | Hospital | Cost | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | Commission of the Commission o | and the same and t | 1.00 | |
| 1.00 | Medical and other services (see instructions) | | | 4,556,993 | 1.0 |
| 2.00 | Medical and other services reimbursed under OPPS (see instru | ctions) | | 4,550,993 | 1 |
| 3.00 | PPS payments | | | 0 | |
| 4.00 5.00 | Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instru | | | 0 | 1 |
| 6.00 | Line 2 times line 5 | uctions) | | 0.000 | |
| 7.00 | Sum of line 3 plus line 4 divided by line 6 | | | 0.00 | |
| 8.00 | Transitional corridor payment (see instructions) | | | . 0 | |
| 9.00 10.00 | Ancillary service other pass through costs from Worksheet D, Organ acquisitions | Part IV, column 13, line | 200 | 0 | |
| | Total cost (sum of lines 1 and 10) (see instructions) | | | 0 4,556,993 | |
| | COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges | | , | | 11.0 |
| 12 00 | - Non- an amendment of the National Advantage of the National Advantag | | | | |
| 13.00 | Ancillary service charges Organ acquisition charges (from Worksheet D-4, Part III, line | - 603 40 | | | 12.0 |
| 14.00 | Total reasonable charges (sum of lines 12 and 13) | e 69, COI. 4) | | | 13.0 |
| | Customary charges | | | | 14.0 |
| 15.00 | Aggregate amount actually collected from patients liable for | payment for services on | a charge basis | 0 | 15.0 |
| 16.00 | Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR 413.13(e | or payment for services o | n a chargebasis | 0 | 16.0 |
| 17.00 | Ratio of line 15 to line 16 (not to exceed 1.000000) | e) | İ | 0.000000 | 17.0 |
| 18.00 | Total customary charges (see instructions) | | | 0.000000 | ! |
| 19.00 | Excess of customary charges over reasonable cost (complete or instructions) | nly if line 18 exceeds li | ne 11) (see | | 19.0 |
| 20.00 | Excess of reasonable cost over customary charges (complete or | alv if lime 11 average 32 | 10) (| | |
| | INSTRUCTIONS | | ne 18) (see | 0 | 20.0 |
| 21.00 | Lesser of cost or charges (line 11 minus line 20) (for CAH se | ee instructions) | | 4,602,563 | 21.0 |
| 22.00 | Interns and residents (see instructions) | | | 0 | _ |
| 24.00 | Cost of teaching physicians (see instructions, 42 CFR 415.160 Total prospective payment (sum of lines 3, 4, 8 and 9) |) and CMS Pub. 15-1, sect | ion 2148) | | 23.0 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | Control of Control of | | | 24.0 |
| 25.00 | Deductibles and coinsurance (for CAH, see instructions) | | | 56,570 | 25.0 |
| 26.00 27.00 | Deductibles and Coinsurance relating to amount on line 24 (fo | or CAH, see instructions) | | 2,568,396 | |
| 27.00 | Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus see instructions) | s the sum of lines 22 and | 23} (for CAH, | 1,977,597 | 27.0 |
| 28.00 | Direct graduate medical education payments (from Worksheet F- | -4. line 50) | i | n | 28.0 |
| 29.00 | ESRD direct medical education costs (from worksheet F-4. line | 2 36) | | , | 29.0 |
| 30.00 | Subtotal (sum of lines 27 through 29) Primary payer payments | | | 1,977,597 | |
| 32.00 | Subtotal (line 30 minus line 31) | | | | 31.0 |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI | CES) | | 1,976,770 | 32.0 |
| 33.00 | Composite rate ESRD (from Worksheet I-5, line 11) | | 1 | 0 | 33.0 |
| 34.00 | Allowable bad debts (see instructions) | | Ì | 358,878 | |
| 36.00 | Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst | | İ | 358,878 | |
| 37.00 | Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospita | Tructions) | : | 166,730 | 36.00 |
| 00.00 | MSP-LCC reconciliation amount from PS&R | (1) and subprovider only) | | 2,335,648 | 37.0 |
| 39.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 1 | 39.0 |
| 9.98 | AB Re-billing demo amount (see instructions) RECOVERY OF ACCELERATED DEPRECIATION | | | | 39.9 |
| 0.00 | Subtotal (line 37 plus or minus lines 39 minus 38) | | | | 39.99 |
| 1.00 | Interim payments | | | 2,335,648 | |
| 2.00 | Tentative settlement (for contractors use only) | | | 2,276,803 | 41.00 |
| 13.00 | Balance due provider/program (line 40 minus the sum of lines. | 41, and 42) | | 58,845 | |
| 14.00 | Protested amounts (nonallowable cost report items) in accorda TO BE COMPLETED BY CONTRACTOR | | | | 44.00 |
| 90.00 | Original outlier amount (see instructions) | VA | | | |
| 1.00 | Outlier reconciliation adjustment amount (see instructions) | | | | 90.00 |
| 12.00 | The rate used to calculate the Time Value of Money | | | | 91.00 |
| 93.00 | Time Value of Money (see instructions) | | | | 93.00 |
| ,4.00 | Total (sum of lines 91 and 93) | | | | 94.00 |

| ANALY | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider | | Period: From 01/01/2012 To 12/31/2012 | | pared: |
|--------------|--|-----------------------------|---------------------|---|-----------------------------|----------------------|
| | The second secon | Title Inpatient | e XVIII t Part A | Hospital Pa | Cost rt B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| 1.00 | Agrange and a second of the se | 1.00 | 2.00 | 3.00 | 4.00 | |
| 3.00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate | | 4,501,31 | 7 | 1,877,403 | 1.00 2.00 3.00 |
| | for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| 3.01 | Program to Provider ADJUSTMENTS TO PROVIDER | 1 00 (00 (2012 T | | | 4 | |
| 3.02 | ADJUSTINENTS TO PROVIDER | 09/05/2012 | 105,80 | 0 09/05/2012 | 399,400 | 3.01 |
| 3.03 | | | | 0 | 0 | 3.02 |
| 3.04 | | | | 0 | 0 | 3.03 3.04 |
| 3.05 | | | | 0 | 0 | 3.04 |
| | Provider to Program | · american construction and | | 74 | - · · · · · | 3.03 |
| 3.50 3.51 | ADJUSTMENTS TO PROGRAM | İ | | 0 | 0 | 3.50 |
| 3.52 | | | | 0 | 0 | 3.51 |
| 3.53 | | | | 0 | 0 | 3.52 |
| 3.54 | | | | 0 | . 0 | 3.53 |
| 3.99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | 105,80 | | 0 399,400 | 3.54 3.99 |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR | | 4,607,11 | 7 | 2,276,803 | 4.00 |
| 5.00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | 5.00 |
| 5.01 | Program to Provider TENTATIVE TO PROVIDER | | | | | |
| 5.02 | SEMINITAE IO SKOATDEK | | | 0 | 0 | 5.01 |
| 5.03 | : | | | 0 | 0 | 5.02 |
| | Provider to Program | | | <i>y</i> ! | 0 | 5.03 |
| 5.50 | TENTATIVE TO PROGRAM | | | O I | 0 | 5.50 |
| 5.51 | | | Č | | ő | 5.51 |
| 5.52 5.99 | Cubana Caus Cat Can Can Can | | (| o | 0 | 5.52 |
| 6.00 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | (|) | 0 | 5.99 |
| 6.00 | Determined net settlement amount (balance due) based on the cost report. (1) | 200 | | | | 6.00 |
| 6.02 | SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM | | 484,856 | 5 | 58,845 | 6.01 |
| 7.00 | Total Medicare program liability (see instructions) | | E 001 077 |) | 0 | 6.02 |
| | total for the state of the tract definity | | 5,091,973 | # TOTAL COMMENT | 2,335,648 | 7.00 |
| | | 0 | | Contractor Number 1.00 | Date (Mo/Day/Yr) 2.00 | |
| 8.00 | Name of Contractor | | | | | 8.00 |

| ANALY | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | | CCN: 151322 CCN: 15Z322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I Date/Time Pre 5/30/2013 9:1 | pared: |
|--------------|--|--|----------------------------|---|---|--------------|
| | | and the contract of the contra | e XVIII t Part A | Swing Beds - SNI Pai | | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| 1.00 2.00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | 1.00 | 2.00 857,89 | 3.00 | 4.00 | 2.00 |
| | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 3.00 |
| 3.01 | ADJUSTMENTS TO PROVIDER | 09/05/2012 | 50,60 | 00 | 0 | 3.01 |
| 3.02 3.03 | | | | 0 | 0 | 3.02 |
| 3.04 | | | | 0 | 0 | |
| 3.05 | | | | 0 | 0 | 3.04 |
| | Provider to Program | l | L | <u>U</u> | 0 | 3.05 |
| 3.50 | ADJUSTMENTS TO PROGRAM | | | 0 | 0 | 3.50 |
| 3.51 | | | | 0 | ŏ | |
| 3.52 | | | | 0 | 0 | |
| 3.53 | | | | 0 | 0 | 3.53 |
| 3.54 3.99 | Subtotal (sum of lines 2 01 2 40 minus and 2 14 | | | 0 | 0 | |
| 3.33 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | 50,60 | 00 | 0 | 3.99 |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate) | | 908,49 | 92 | 0 | 4.00 |
| | TO BE COMPLETED BY CONTRACTOR | | | | | |
| 5.00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | : ! ! | 5.00 |
| 5.01 | TENTATIVE TO PROVIDER | | | 0 | 0 | 5.01 |
| 5.02 | | | | 0 | ŏ | |
| 5.03 | Drovi don to Brown | | | 0 | 0 | 5.03 |
| 5.50 | Provider to Program TENTATIVE TO PROGRAM | , | | • | | _ |
| 5.51 | | | | 0 | 0 | |
| 5.52 | | | | 0 | 0 0 | 5.51 5.52 |
| 5.99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | | Ö | 0 | 5.99 |
| 5.00 5.01 | Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER | | 440 44 | . | _ | 6.00 |
| 5.02 | SETTLEMENT TO PROGRAM | | 118,41 | .5 | 0 | 6.01 |
| 7.00 | Total Medicare program liability (see instructions) | | 1,026,90 | • | 0 | 6.02 7.00 |
| | | | | Contractor Number | Date (Mo/Day/Yr) | 7.00 |
| 3.00 | Name of Contractor | C | 1 | 1.00 | 2.00 | 8.00 |

| | Financial Systems PERRY COUNTY | - constitution - cons | TILLIE | u of Form CMS-Z | |
|--------|--|--|---|---|--------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | | pared: |
| | And the second of the second o | Title XVIII | Hospital | Cost | |
| | | | | 1.00 | - |
| | TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS | | | and the title of the booking of the control of the | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | | | | |
| .00 | The state of the s | | | | |
| .00 | Medicare days from Wkst S-3, Part I, column 6 sum of lines 1 | , 8-12 | | 2,627 | 2.00 |
| .00 | Medicare HMO days from Wkst S-3, Part I, column 6. line 2 | | | 122 | 3.00 |
| .00 | Total inpatient days from S-3, Part I column 8 sum of lines | | | 3,974 | 4.00 |
| .00 | Total hospital charges from Wkst C, Part I, column 8 line 200 | 0 | | 67,789,214 | 5,00 |
| 5.00 | Total hospital charity care charges from wkst S-10, column 3 | line 20 | | 2,143,877 | 6.00 |
| 7.00 | CAH only - The reasonable cost incurred for the purchase of Part I line 168 | certified HIT technology | Worksheet S-2, | 908,819 | |
| 3.00 | Calculation of the HIT incentive payment (see instructions) | | | 831.021 | 8.00 |
| | INPATIENT HOSPITAL SERVICES UNDER PPS & CAH | | | | 0.00 |
| 30.00 | Initial/interim HIT payment adjustment (see instructions) | | | 822,299 | 30.00 |
| | Other Adjustment (specify) | | İ | 0 | 31.00 |
| 32.00 | Balance due provider (line 8 minus line 30 and line 31) | | | 8,722 | |

| | Financial Systems PERRY COUNTY HOS | | In Lie | u of Form CMS- | 2552-1 |
|--------|--|---|---|--------------------------------|--------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 151322 | Period: From 01/01/2012 | Worksheet E-2 | |
| | | Component CCN: 15Z322 | To 12/31/2012 | Date/Time Pre 5/30/2013 9:1 | |
| | CONTRACTOR MARKET TO A MARKET TO THE CONTRACT TO THE CONTRACTOR TO | Title XVIII | Swing Beds - SNF | Cost | |
| | | | Part A | Part B | |
| | The second distribution of the same of the | The well-specific and anomaly states of the second states and | 1.00 | 2.00 | |
| 1 00 | COMPUTATION OF NET COST OF COVERED SERVICES | | e merenga in a responsable com in a contraction accessorable ga | | |
| 1.00 | Inpatient routine services - swing bed-SNF (see instructions) | | 770,310 | 0 | 1.00 |
| 2.00 | Inpatient routine services - swing bed-NF (see instructions) | | | | 2.00 |
| | Ancillary services (from Wkst. D-3, column 3, line 200 for Part Part V, columns 5 and 7, line 202 for Part B) (For CAH, see inst | tructions) | , 263,100 | 0 | 3.00 |
| 4.00 | Per diem cost for interns and residents not in approved teaching instructions) | g program (see | | 0.00 | 4.00 |
| 5.00 | Program days | | 631 | 0 | 5.00 |
| 6.00 | Interns and residents not in approved teaching program (see inst | tructions) | | 0 | 6.00 |
| 7.00 | Utilization review - physician compensation - SNF optional metho | od only | 0 | - | 7.0 |
| 8.00 | Subtotal (sum of lines 1 through 3 plus lines 6 and 7) | | 1,033,410 | 0 | 8.00 |
| 9.00 | Primary payer payments (see instructions) | | 0 | ō | |
| 10.00 | Subtotal (line 8 minus line 9) | | 1,033,410 | Ō | 10.00 |
| | Deductibles billed to program patients (exclude amounts applicate professional services) | ole to physician | 0 | 0 | 11.00 |
| 12.00 | Subtotal (line 10 minus line 11) | | 1,033,410 | 0 | 12.00 |
| | Coinsurance billed to program patients (from provider records) (for physician professional services) | (exclude coinsurance | 6,503 | 0 | |
| 14.00 | 80% of Part B costs (line 12 x 80%) | | | 0 | 14.00 |
| 15.00 | Subtotal (enter the lesser of line 12 minus line 13, or line 14) | 1 | 1,026,907 | 0 | 15.00 |
| 16.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | 0 | 0 | 16.00 |
| 17.00 | Reimbursable bad debts (see instructions) | | 0 | 0 | 17.00 |
| 18.00 | Reimbursable bad debts for dual eligible beneficiaries (see inst | ructions) | 0 | 0 | 18.00 |
| 19.00 | Total (sum of lines 15 and 17, plus/minus line 16) | | 1,026,907 | 0 | 19.00 |
| | Interim payments | | 908,492 | 0 | |
| 21.00 | Tentative settlement (for contractor use only) | | 0 | - 1 | 21.00 |
| 22.00 | Balance due provider/program (line 19 minus the sum of lines 20 | and 21) | 118,415 | | |
| 23.00 | Protested amounts (nonallowable cost report items) in accordance section 115.2 | with CMS Pub. 15-II, | 0 | 0 | 23.00 |

| CALCULATION OF REIMBURSEMENT SETILEMENT Provider CCN: 151322 Period: From 01/01/2012 Part Proposition 12/31/2012 Part V - CALCULATION OF REIMBURSEMENT SETILEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS) 1.00 Inpatient services 1.00 Subtotal (sum of lines 1 thru 3) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0. | | Financial Systems PERRY COUNTY | Y HOSPITAL | In Lie | u of Form CMS- | 2552-10 |
|--|----------------|--|--|------------------|-------------------------|---------|
| PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAMS) 1.00 Inpatient services 2.00 Inpatient services 3.01 3.00 Organ acquisition 4.00 3.00 Organ acquisition 5.516,655 5.00 Primary payer payments 6.00 Total cost (line 4 less line 5). For CAH (see instructions) 6.07 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 7.00 Routine service charges 9.00 Organ acquisition charges, net of revenue 10.00 Total customary charges, net of revenue 10.00 Total customary charges 11.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 cra 413.13(e) 13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) Total customary charges (see instructions) 16.00 Excess of customary charges (see instructions) 17.00 Cost of covered services (sum of lines 6, 17 and 18) 18.00 Direct graduate medical education payments (from worksheet E-4, line 49) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 19.00 Cost of customary charges (see instructions) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 2.00 Distructions (line 22 minus line 23) 2.00 Deductibles (exclude pad debts for professional services) (see instructions) 3.61,884 3.60 Allowable bad debts (exclude bad debts for professional services) (see instructions) 3.60 Allowable bad debts (exclude bad debts for professional services) (see instructions) 3.60 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 3.60 3 | CALCUI | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151322 | From 01/01/2012 | Part V Date/Time Pre | pared: |
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| COMPUTATION OF REIMBURSEMENT SETTLEMENT 8.00 Direct graduate medical education payments (from worksheet E-4, line 49) 0 cost of covered services (sum of lines 6, 17 and 18) 10 Deductibles (exclude professional component) 10 Excess reasonable cost (from line 16) 11 Deductibles (exclude professional component) 12 Deductibles (exclude professional component) 13 Deductibles (exclude professional component) 14 Subtotal (line 19 minus line 20) 15 Deductibles (exclude professional component) 15 Deductibles (exclude payments) 15 Deductibles (exclude payments) 15 Deductibles (exclude payments) 16 Deductibles (exclude payments) 17 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Deductibles (exclude payments) 18 Ded | 17.00 | Cost of teaching physicians (from Worksheet D-5, Part II, c | column 3, line 20) (see ins | tructions) | 0 | 17.00 |
| 19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 31.00 Interim payments 5,571,822 563,888 0 5,007,934 0 5,007,934 0 5,007,934 0 5,007,934 0 6,007,934 0 6,007,934 0 6,007,934 0 7,007,934 | 10 00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 20.00 Deductibles (exclude professional component) 100 Excess reasonable cost (from line 16) 101 Excess reasonable cost (from line 16) 102.00 Subtotal (line 19 minus line 20) 103.00 Coinsurance 104.00 Subtotal (line 22 minus line 23) 105.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 106.00 Adjusted reimbursable bad debts (see instructions) 107.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 108.00 Subtotal (sum of lines 24 and 25, or line 26) 109.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 100 Recovery of Accelerated Depreciation 101 Subtotal (line 28, plus or minus lines 29) 102 Subtotal (line 28, plus or minus lines 29) 103 Subtotal (line 28, plus or minus lines 29) 105 Signal (line 28, plus or minus lines 29) 116 Signal (line 28, plus or minus lines 29) 117 Signal (line 28, plus or minus lines 29) | 18.00 | Direct graduate medical education payments (from Worksheet | E-4, line 49) | | 0 | 18.00 |
| 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20) 3.00 Coinsurance 4.00 Subtotal (line 22 minus line 23) 5.007,934 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 6.00 Adjusted reimbursable bad debts (see instructions) 7.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 84,039 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 34,128 34,039 34,128 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9.99 Recovery of Accelerated Depreciation 0 Subtotal (line 28, plus or minus lines 29) 1.00 Interim payments | 19.00 | Cost of covered services (sum of lines 6, 17 and 18) | | | 5,571,822 | 19.00 |
| 22.00 Subtotal (line 19 minus line 20) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 31.00 Interim payments 5,007,934 5,007,934 5,007,934 6,007 | 20.00 | Deductibles (exclude professional component) | | | 563,888 | 20.00 |
| 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 5,007,934 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 84,039 27.00 Allowable bad debts (see instructions) 84,039 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 34,128 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 29.99 Recovery of Accelerated Depreciation 0 Subtotal (line 28, plus or minus lines 29) 31.00 Interim payments | 22.00 | Excess reasonable cost (from line 16) | | | | 21.00 |
| 24.00 Subtotal (line 22 minus line 23) 5,007,934 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 64,039 27.00 Allowable bad debts (see instructions) 84,039 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 80 80 80 80 80 80 80 80 80 8 | 22.00 | Coincurance | | | | |
| 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 31.00 Interim payments 34,039 84,039 5,091,973 | | | | | | 23.00 |
| 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 31.00 Interim payments 84,039 34,128 5,091,973 | 24.00 25 AA | Allowable had debte (avaluate text the S | | | | |
| 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 34,128 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 31.00 Interim payments 4.607,117 | 26.00 | Adjusted painbursehile had debts for professional ser | vices) (see instructions) | | , | |
| 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 31.00 Interim payments 5,091,973 | 27 00 | Allowable had debts for dual aliable hereft in | | | • | |
| 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 31.00 Interim payments | 28 00 | Subtotal (sum of lines 24 and 25 and 26) | structions) | | , | |
| 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 31.00 Interim payments | 20.00 | OTHER ADDICTMENTS (SEE THETRUCTTONS) (SPECTS) | | | | |
| 30.00 Subtotal (line 28, plus or minus lines 29) 5,091,973 11.00 Interim payments | 29 90 | Recovery of Accelerated Depreciation | | | | 29.00 |
| 31.00 Interim payments | 30.00 | Subtotal (line 28 plus or minus lines 20) | | | | 29.99 |
| 4,607,117 | 31.00 | Interim payments | | | | |
| 32.UU 18BTATIVE SATTISMENT (for contractor use only) | 32.00 | Tentative settlement (for contractor use only) | | İ | | |
| 33 00 Palanco dua providar (nuescom (14m 20 minus et m. C. 7 con et man | 33.00 | Balance due provider/program (line 20 minus the aum of line | - 21 22) | i | | 32.00 |
| 34 00 Protected amounts (non-31 aughla sant manage (4 aug) | 34.00 | Protested amounts (nonallowable cost report items) in annual | dense with second at 2 | 115 3 | | |
| 0 | | and an accordance cost report reals) in accordance | dance with CMS Pub. 15-2, s | section 115.2 | 0 | 34.00 |

| | n Financial Systems PERRY COUNTY CE SHEET (If you are nonproprietary and do not maintain | | CCN+ 151322 | | u of Form CMS- | 2552-10 |
|----------------|--|---------------------------------------|--------------------------|---|---------------------------|----------------|
| fund- | type accounting records, complete the General Fund column on | ly) Provider | | Period: From 01/01/2012 To 12/31/2012 | Worksheet G Date/Time Pre | pared: |
| | | General Fund | Specific Purpose Fund | Endowment Fund | 5/30/2013 9:1 | |
| | CUBREAGE | 1.00 | 2.00 | 3.00 | 4.00 | |
| 1.00 | CURRENT ASSETS Cash on hand in banks | 5,412,668 | | 0 0 | | 1 00 |
| 2.00 | Temporary investments | 3,412,000 | | 0 0 | 0 | |
| 3.00 | Notes receivable | 0 | 1 | 0 0 | ŏ | 3.00 |
| 4.00 5.00 | Accounts receivable | 10,190,302 | | 0 0 | 0 | 1 |
| 6.00 | Other receivable Allowances for uncollectible notes and accounts receivable | 59,385 | | 0 0 | 0 | |
| 7.00 | Inventory | -3,500,148 709,824 | | 0 0 | 0 | 6.00 7.00 |
| 8.00 | Prepaid expenses | 642,599 | | 0 0 | 0 | 8.00 |
| 9.00 | Other current assets | 8,531,941 | | 0 0 | 0 | 1 |
| | Due from other funds Total current assets (sum of lines 1-10) | 22 046 571 | | 0 0 | 0 | 10.00 |
| 11.00 | FIXED ASSETS | 22,046,571 | 1 | 0 0 | 0 | 11.00 |
| | Land | · · · · · · · · · · · · · · · · · · · | | 0 0 | 0 | 12.00 |
| | Land improvements | 0 | | 0 0 | Ö | |
| 14.00 | Accumulated depreciation Buildings | 0 | | 0 0 | 0 | 14.00 |
| 16.00 | Accumulated depreciation | 33,603,878 -20,120,903 | i . | 0 0 | 0 | |
| 17.00 | Leasehold improvements | -20,120,903 | | 0 0 | 0 | |
| | Accumulated depreciation | Ö | | 0 0 | Ö | 1 |
| 30 00 TA'00 | Fixed equipment Accumulated depreciation | 0 | i | 0 0 | 0 | 19.00 |
| 21.00 | Automobiles and trucks | 0 | 1 | 0 0 | 0 | |
| 22.00 | Accumulated depreciation | 0 | | 0 0 | 0 | |
| | Major movable equipment | ŏ | ì | 0 0 | 0 | ; |
| | Accumulated depreciation | 0 | | 0 0 | Ō | |
| | Minor equipment depreciable Accumulated depreciation | 0 | | 0 0 | 0 | |
| 27.00 | HIT designated Assets | 0 | | 0 0 | 0 | |
| 28.00 | Accumulated depreciation | ő | 1 | 0 0 | 0 0 | |
| 29.00 | Minor equipment-nondepreciable | 0 | Į. | 0 0 | Ö | |
| 30.00 | Total fixed assets (sum of lines 12-29) OTHER ASSETS | 13,482,975 | (| 0 0 | 0 | |
| 31.00 | Investments | 0 | i | n! n: | | |
| 32.00 | Deposits on leases | 0 | 1 - | 0 0 | 0 | |
| 33.00 | Due from owners/officers | 0 | | o o | ő | |
| | Other assets Total other assets (sum of lines 31-34) | 1,002,503 | | 0 | 0 | |
| 36.00 | Total assets (sum of lines 11, 30, and 35) | 1,002,503 | | 0 | 0 | 35.00 |
| | CURRENT LIABILITIES | 36,532,049 | | 0 | 0 | 36.00 |
| 37.00 | Accounts payable | 595,597 | | 0 | 0 | 37.00 |
| 38.00 | Salaries, wages, and fees payable Payroll taxes payable | 939,226 | | 0 | o | |
| 40.00 | Notes and loans payable (short term) | 450.705 | | 0 | 0 | 39.00 |
| 41.00 | Deferred income | 450,795 0 | (| - 1 | 0 | 40.00 |
| | Accelerated payments | ŏ | ` | | 0 | 41.00 42.00 |
| | Oue to other funds | 0 | | 0 | 0 | 43.00 |
| 45.00 | Other current liabilities Total current liabilities (sum of lines 37 thru 44) | 1,577,715 | | 0 | | 44.00 |
| | LONG TERM LIABILITIES | 3,563,333 | | 0 | 0 | 45.00 |
| | Mortgage payable | 0 | (| 0 | n | 46.00 |
| | Notes payable | 1,185,063 | Ć | 0 | | 47.00 |
| | Unsecured loans Other long term liabilities | 0 | (| 1 | 1 | 48.00 |
| 50.00 | Total long term liabilities (sum of lines 46 thru 49 | 1,185,063 | (| ' | | 49.00 |
| 51.00 | Total liabilites (sum of lines 45 and 50) | 4,748,396 | - | 0 | | 50.00 51.00 |
| | CAPITAL ACCOUNTS | 1 11 00 - 1 21 man | | ····· · · · · · · · · · · · · · · · · | | 51.00 |
| | General fund balance Specific purpose fund | 31,783,653 | _ | | ~ . | 52.00 |
| 54.00 | Donor created - endowment fund balance - restricted | | C | 0 | | 53.00 |
| 55.00 | Donor created - endowment fund balance - unrestricted | | | 0 | : | 54.00 55.00 |
| 56.00 | Governing body created - endowment fund balance | - | | 0 | | 56.00 |
| 58.00 | Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, | | | | | 57.00 |
| | replacement, and expansion | | | | 0 | 58.00 |
| 59.00 | Total fund balances (sum of lines 52 thru 58) | 31,783,653 | 0 | 0 | 0 | 59.00 |
| 60.00 | Total liabilities and fund balances (sum of lines 51 and | 36,532,049 | Ö | Ö | : | 60.00 |
| | 59) | 1 | | ! | | |

| SIAIE | MENT OF CHANGES IN FUND BALANCES | | Provider | CCN: 151322 | Fro | riod: om 01/01/2012 | Worksheet | | |
|--------------|--|----------------|--|-------------|--------|-------------------------|-------------------------------------|------|---------------|
| | the state of the second state as a second decreased as a second state of the second st | General | Fund | Snecial | To | 12/31/2012 pose Fund | Date/Time 5/30/2013 Endowment | 9:1 | pared 3 am |
| | | | Secondary and a secondary of the seconda | Special | , w. p | rose rana | LITOMMETTE | runu | |
| | | 1 00 | 2.00 | 3 00 | | | 12112 | | |
| L.00 | Fund balances at beginning of period | 1.00 | 2.00 30,614,665 | 3.00 | | 4.00 | 5.00 | | 1.0 |
| .00 | Net income (loss) (from Wkst. G-3, line 29) | | 1,142,857 | i | | U | | | 2.0 |
| .00 | Total (sum of line 1 and line 2) | | 31,757,522 | | | 0 | | | 3.0 |
| .00 | Additions (credit adjustments) (specify) | 26,131 | | | 0 | | | 0 | 4.0 |
| .00 | | 0 | | | 0 | | | 0 | 5.0 |
| .00 | | 0 | | | 0 | | | 0 | 6.0 |
| .00 | | 0 | | | 0 | | | 0 | 1 |
| .00 | | 0 | | | 0 | | | 0 | 8. |
| 0.00 | Total additions (sum of line 4-9) | U | 26,131 | | U | 0 | | 0 | |
| 1.00 | Subtotal (line 3 plus line 10) | | 31,783,653 | | | 0 | | | 10. 11. |
| 2.00 | Deductions (debit adjustments) (specify) | 0 | 52,.05,055 | | 0 | Ŭ | | 0 | |
| 3.00 | | 0 | | | o | | | ő | |
| 4.00 | | 0 | | | 0 | | | ō | |
| 5.00 | | 0 | | | 0 | | | 0 | 15. |
| 6.00 7.00 | • | 0 | | | 0 | | | . 0 | |
| 8.00 | Total deductions (sum of lines 12-17) | U | | | 0 | | | 0 | |
| 9.00 | Fund balance at end of period per balance | | 31,783,653 | | | 0 | | | 18.0 |
| | sheet (line 11 minus line 18) | | 31,763,033 | | | U | | | 19.0 |
| | | Endowment Fund | Plant | Fund | | , | | | |
| | | 6.00 | 7.00 | 8.00 | | | | | |
| .00 | Fund balances at beginning of period | 0 | 1.52 | | 0 | | | | 1.0 |
| .00 | Net income (loss) (from wkst. G-3, line 29) | | | | İ | | | | 2.0 |
| .00 | Total (sum of line 1 and line 2) | 0 | | | 0 | | | | 3.0 |
| .00 .00 | Additions (credit adjustments) (specify) | | 0 | | | | | | 4.0 |
| .00 | | | 0 | | - | | | | 5.0 |
| .00 | | | 0 | | | | | | 6.0 |
| .00 | | | 0 | | į | | | | 7.0 |
| 00 | | | o | | | | | | 8. 9. |
| | Total additions (sum of line 4-9) | 0 | ١ | | 0 | | | 1 | 10.0 |
| .00 | Subtotal (line 3 plus line 10) | 0 | | | 0 | | | | 11. |
| 2.00 | Deductions (debit adjustments) (specify) | | 0 | | | | | | 12. |
| 1.00 | | | 0 | | | | | | 13.0 |
| 5.00 | | | 0 | | : | | | | 14.0 |
| 5.00 | - | | 0 | | - | | | Ī | 15.0 |
| 7.00 | | | 0 | | : | | | | 16.0 |
| 8.00 | Total deductions (sum of lines 12-17) | 0 | U | | n | | | | 17.0 18.0 |
| | Fund balance at end of period per balance | | | | | | | | 170 1 |

| | n Financial Systems PERRY COUNTY HOSP | TAL | | In Lie | u of Form CMS- | 2552-10 |
|-------|--|----------------------|----------------------------|---|---|---------|
| STATE | MENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider | CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-2 Parts I & II Date/Time Pre 5/30/2013 9:1 | pared: |
| | Cost Center Description | | Inpatient 1.00 | Outpatient | Total | .5 am |
| | PART I - PATIENT REVENUES | | 1.00 | 2.00 | 3.00 | |
| | General Inpatient Routine Services | 17.1 (0.7.70) (0.00) | estable to considerate the | The second second second | remproprieting, | |
| 1.00 | Hospital | | 3,365,92 | 8 | 3,365,928 | 1.00 |
| 2.00 | SUBPROVIDER - IPF | | 3,303,31 | | 3,303,320 | 2.00 |
| 3.00 | SUBPROVIDER - IRF | | | | | 3.00 |
| 4.00 | SUBPROVIDER | | | | | 4.00 |
| 5.00 | Swing bed - SNF | | | 0 | 0 | |
| 6.00 | Swing bed - NF | | | 0 | Ö | 1 |
| 7.00 | SKILLED NURSING FACILITY | | | | • | 7.00 |
| 8.00 | NURSING FACILITY | | | | | 8.00 |
| 9.00 | OTHER LONG TERM CARE | | | | | 9.00 |
| | Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services | | 3,365,92 | 18 | 3,365,928 | |
| 11.00 | | | 972,10 |)2 | 972,102 | 11.00 |
| 12.00 | CORONARY CARE UNIT | | | | | 12.00 |
| | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT | | | | | 13.00 |
| | OTHER SPECIAL CARE (SPECIFY) | | | | | 14.00 |
| 16.00 | Total intensive same type impatient benefit | | | _ | | 15.00 |
| | Total intensive care type inpatient hospital services (sum of lin 11-15) | es | 972,10 | 12 | 972,102 | 16.00 |
| 10 00 | Total inpatient routine care services (sum of lines 10 and 16) Ancillary services | | 4,338,03 | | 4,338,030 | 17.00 |
| | Outpatient services | | 16,431,78 | 3 42,624,828 | 59,056,611 | 18.00 |
| 20.00 | RURAL HEALTH CLINIC | | | 0 | 0 | 19.00 |
| 21 00 | FEDERALLY QUALIFIED HEALTH CENTER | | | 0 | 0 | 20.00 |
| 22 00 | HOME HEALTH AGENCY | | | 0 | 0 | |
| 23.00 | AMBULANCE SERVICES | | | 2,121,397 | 2,121,397 | |
| 24.00 | CMHC | | | 0 2,273,176 | 2,273,176 | 1 |
| | AMBULATORY SURGICAL CENTER (D.P.) | | | | | 24.00 |
| 26.00 | HOSPICE | | | | _ | 25.00 |
| 27.00 | PRO FEES | | 218,83 | 0 0 | | 26.00 |
| 28.00 | Total patient revenues (sum of lines 17-27)(transfer column 3 to | wke+ | 20,988,65 | | 5,202,947 | |
| | G-3, line 1) | WKSt. | 20,900,03 | 2 52,003,509 | 72,992,161 | 28.00 |
| | PART II - OPERATING EXPENSES | | man and a second | 3 4 | | |
| 29.00 | Operating expenses (per Wkst. A, column 3, line 200) | | | 33,734,986 | | 29.00 |
| 30.00 | ADD (SPECIFY) | | | 0 | | 30.00 |
| 31.00 | | | | 0 | : | 31.00 |
| 32.00 | | | | 0 | | 32.00 |
| 33.00 | | | | 0 | | 33.00 |
| 34.00 | | | | 0 | | 34.00 |
| 35.00 | Total additions (| | | 0 | | 35.00 |
| 37.00 | Total additions (sum of lines 30-35) | | | 0 | 1 | 36.00 |
| 38.00 | NON-OPERATING EXPENSES | | 4,325,08 | 9 | | 37.00 |
| 39.00 | | | | 0 | | 38.00 |
| 40.00 | | | 1 | 0 | | 39.00 |
| 41.00 | | | + | 0 | | 40.00 |
| | Total deductions (sum of lines 37-41) | | • | 0 | | 41.00 |
| 43.00 | Total operating expenses (sum of lines 29 and 36 minus line 42)(tr | | | 4,325,089 | | 42.00 |
| | to wkst. G-3, line 4) | anster | | 29,409,897 | | 43.00 |

| Health Financial Systems | р | ERRY COUNTY HOSPITAL | In Lie | In Lieu of Form CMS-2 | | |
|----------------------------------|--|---|--|---|--------|--|
| STATEMENT OF REVENUES AND EXPEN | ISES | Provider CCN: 151 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-3 Date/Time Pre 5/30/2013 9:1 | pared: | |
| | | | | 1.00 | | |
| 1.00 Total patient revenues (1 | from Wkst. G-2, Part I, | column 3, line 28) | | 72,992,161 | 1.00 | |
| 2.00 Less contractual allowand | ces and discounts on pat | ients' accounts | | 42,002,154 | | |
| 3.00 Net patient revenues (lin | ne 1 minus line 2) | | | 30,990,007 | | |
| 4.00 Less total operating expe | enses (from Wkst. G-2, Pa | art II, line 43) | | 29,409,897 | | |
| 5.00 Net income from service t | to patients (line 3 minus | s line 4) | | 1,580,110 | | |
| OTHER INCOME | - The symbolic participation of the following state of the state of th | the transfer and the second section is a second second section of the second section is a second section of the | nga papahalahan najaman phajahan dana hijakan pana Milaya Pengulan anala ani dani yan angan da da da da da da da da da da da da da | | | |
| 6.00 Contributions, donations, | , bequests, etc | | | 0 | 6.00 | |
| 7.00 Income from investments | | | | 367,809 | 7.00 | |
| 8.00 Revenues from telephone a | | | | 0 | 8.00 | |
| 9.00 Revenue from television a | and radio service | | | 0 | 9.00 | |
| 10.00 Purchase discounts | | | | 0 | 10.0 | |
| 11.00 Rebates and refunds of ex | xpenses | | | 0 | 11.0 | |
| 12.00 Parking lot receipts | | | | 0 | 12.0 | |
| 13.00 Revenue from laundry and | linen service | | | 0 | 13.0 | |
| 14.00 Revenue from meals sold t | | | | 0 | 14.0 | |
| 15.00 Revenue from rental of li | | | | 0 | 15.00 | |
| 16.00 Revenue from sale of medi | ical and surgical supplic | es to other than patients | | 0 | 16.0 | |
| 17.00 Revenue from sale of drug | gs to other than patients | 5 | | 0 | 17.0 | |
| 18.00 Revenue from sale of medi | | | ! | 0 | 18.00 | |
| 19.00 Tuition (fees, sale of te | extbooks, uniforms, etc.) |) | | . 0 | 19.0 | |
| 20.00 Revenue from gifts, flower | ers, coffee shops, and ca | anteen | | 0 | 20.0 | |
| 21.00 Rental of vending machine | | | | 0 | 21.00 | |
| 22.00 Rental of hospital space | | | | 0 | | |
| 23.00 Governmental appropriation | ons | | | 0 | | |
| 24.00 OTHER REVENUE | | | | 1,340,855 | | |
| 24.01 NON-OPERATING REVENUE | 577 5343 | | | 3,452,304 | | |
| 25.00 Total other income (sum o | | | | 5,160,968 | | |
| 26.00 Total (line 5 plus line 2 | 25) | | • | 6,741,078 | | |
| 27.00 NON-OPERATING EXPENSE | | | | 5,598,221 | | |
| 28.00 Total other expenses (sun | | | | 5,598,221 | | |
| 29.00 Net income (or loss) for | the period (line 26 minu | us line 28) | | 1,142,857 | 29.00 | |

| | SIS OF PROVIDER-BASED HOME HEAL | IN AGENCY COSTS | | | CCN: 151322 | Period: From 01/01/2012 | Worksheet H | |
|----------------|--|--|----------------------|--|--------------------------------|--|--|--------------|
| | | Wanted Street St | | HHA CCN: | 157177 | To 12/31/2012 Home Health | 5/30/2013 9:1 | |
| | The state of the second | ng i i mwaka i | | | na produces pri | Agency I | PPS | |
| | | Salaries | Employee Benefits | Transportation (see | chased | ur Other Costs | Total (sum of cols. 1 thru | |
| | | 1.00 | 2.00 | instructions) | Services 4.00 | 5.00 | 5) 6.00 | |
| | GENERAL SERVICE COST CENTERS | A | | Personal Control of the Control of t | | and an area of the second of t | | - |
| 1.00 | Capital Related - Bldg. & Fixtures | | | (|) | 0 | 0 | 1.0 |
| 2.00 | Capital Related - Movable | | | | | 0 | • | |
| | Equipment | | | | | U | 0 | 2.0 |
| .00 | Plant Operation & Maintenance | 0 | 0 | C | | 0 0 | 0 | 3.0 |
| .00 | Transportation | 0 | 0 | C |) | 0 | 0 | 4.0 |
| 5.00 | Administrative and General HHA REIMBURSABLE SERVICES | 28,042 | . 0 | (|)) | 0 158,338 | 186,380 | 5.0 |
| 5.00 | Skilled Nursing Care | 146,855 | 0 | 14,082 | 1 | 0 0 | 160 037 | |
| 7.00 | Physical Therapy | 0 | 0 | 7,310 | 1 | -1 | 160,937 96,470 | |
| 3.00 | Occupational Therapy | 0 | ō | | 1 | 1 | 44,656 | į. |
| 00.0 | Speech Pathology | 0 | 0 | 0 | 1 | | 4,020 | |
| LO.00 L1.00 | | 2,889 | | 184 | | 0 | 3,073 | i |
| L2.00 | , | 49,233 | 0 | 7,055 | 1 | 0 | 56,288 | |
| 13.00 | , ,, | 0 | 0 | 0 | 1 | 0 0 | 0 | |
| 4.00 | | 0 | - | | 1 | 0 0 | 0 | |
| | HHA NONREIMBURSABLE SERVICES | | | | | Ψ, | U | 14.0 |
| 5.00 | Home Dialysis Aide Services | 0 | • | C | | 0 0 | 0 | 15.0 |
| | Respiratory Therapy | 0 | 0 | C | 1 | 0 | 0 | 16.0 |
| | Private Duty Nursing | 0 | 0 | C | 1 | 0 | 0 | |
| | Health Promotion Activities | 0 | 0 | | | 0 | . 0 | 18.0 |
| 20.00 | Day Care Program | ő | 0 | 0 | | 0 0 | 0 | |
| | Home Delivered Meals Program | 0 | 0 | ď | | 0 0 | 0 | 1 |
| | Homemaker Service | 0 | 0 | O | | 0 0 | Õ | 4 |
| | All Others (specify) Total (sum of lines 1-23) | 66,475 | 0 | 3,079 | 1 | 1 | 71,281 | 23.0 |
| | Tocal (Sum of Titles 1-23) | 293,494 Reclassificati | Reclassified | 37,042 Adjustments | from a second or a constant | e distribution of the contract of the contract of | 623,105 | 24.0 |
| | | on | Trial Balance | Aujuschients | Net Expenses for Allocation | | | İ |
| | | | (col. 6 + | | (col. 8 + col | | | |
| | | 7.00 | col.7) | | 9) | | ······································ | , |
| | GENERAL SERVICE COST CENTERS | 7.00 | 8.00 | 9.00 | 10.00 | | ** * * | |
| .00 | Capital Related - Bldg. & | 0 | 0 | | | 0 | - | 1.0 |
| | Fixtures | | | · | | · . | | 1.0 |
| 2.00 | Capital Related - Movable Equipment | 0 | 0 | 0 | | 0 | | 2.0 |
| .00 | Plant Operation & Maintenance | 0 | 0 | 0 | | 0 | | |
| .00 | Transportation | 0 | 0 | 0 | | 0 | | 3.0 |
| .00 | Administrative and General | 157,747 | 344,127 | -2,574 | 341,55 | 3 | | 4.0 5.0 |
| - 00 | HHA REIMBURSABLE SERVICES | | | | | | | 3.0 |
| .00 | Skilled Nursing Care | 0 | 160,937 | 0 | | | | 6.0 |
| .00 | Physical Therapy Occupational Therapy | 0 0 | 96,470 44,656 | 0 | , | | | 7.0 |
| .00 | Speech Pathology | 0 | 44,656 4,020 | 0 | , | | | 8.0 |
| | Medical Social Services | Ö | 3,073 | 0 | ., | | *************************************** | 9.0 10.0 |
| | Home Health Aide | Ō | 56,288 | ő | -, | i |) and on the contract of the c | 11.0 |
| 2.00 | Supplies (see instructions) | 0 | 0 | 0 | | 0 | and the state of t | 12.0 |
| 4.00 | Drugs | 0 | 0 | 0 | | 0 | | 13.0 |
| | HHA NONREIMBURSABLE SERVICES | U _j | 0 | 0 | | 0 | | 14.0 |
| 5.00 | Home Dialysis Aide Services | 0 | 0 | | | 0 | | 15 0 |
| 6.00 | Respiratory Therapy | Ö | o | Ö | | 0 | | 15.0 16.0 |
| | Private Duty Nursing | 0 | 0 | ŏ | | 0 | *************************************** | 17.0 |
| | Clinic | 0 | 0 | 0 | | 0 | | 18.0 |
| | Health Promotion Activities Day Care Program | 0 | 0 | 0 | | 0 | | 19.0 |
| | Home Delivered Meals Program | 0 | 0 | 0 | | 0 | | 20.0 |
| 2.00 | Homemaker Service | 0 | 0 | 0 | | 0 | | 21.0 |
| 3.00 | All Others (specify) | Ŏ | 71,281 | 0 | 71,28 | - 1 | : | 22.00 |
| | Total (sum of lines 1-23) | 157,747 | 780,852 | -2,574 | | | 1 | 43.00 |

Column, 6 line 24 should agree with the worksheet A, column 7, line 101, or subscript as applicable.

| COST ALL | OCATION - HHA GENERAL SERVICE | E COST | PERRY COUNTY | | | CCN: 151322 | Period: | u of Form CMS- Worksheet H-1 | |
|----------|--|--|--|--------|---------------------|-------------------------------------|----------------------------------|---------------------------------|------------|
| | | | | н | HA CCN: | 157177 | From 01/01/2012 To 12/31/2012 | Part I Date/Time Pre | |
| | | | - | + | | | Home Health | 5/30/2013 9:1 PPS | .s am |
| | | * | | | | , | Agency I | | |
| | | | Capital Rela | ated C | osts | | | | |
| | | Net Expenses for Cost Allocation (from Wkst. H, | Bldgs & Fixtures | | able pment | Plant Operation & Maintenance | | Subtotal (cols. 0-4) | |
| | | col. 10) | 1.00 | | 00 | 3.00 | 4.00 | 4A.00 | |
| GE | ENERAL SERVICE COST CENTERS | 1 • | 1.00 | | .00 | 3.00 | 4.00 | 44.00 | |
| | apital Related - Bldg. & | 0 | 0 | | team of the agency. | | 1 | 0 | 1. |
| | ixtures | | | | | | | | |
| | apital Related - Movable quipment | 0 | | | 0 | | | 0 | 2. |
| | lant Operation & Maintenance | 0 | 0 | | 0 | | 0 | 0 | 3. |
| | ransportation | 0 | ő | | 0 | | 0 0 | U | 4. |
| | dministrative and General | 341,553 | - | | ő | | 0 0 | 341,553 | ŧ. |
| | A REIMBURSABLE SERVICES | · · · · · · · · · · · · · · · · · · · | e de la California de l | | | | | | 1 |
| | killed Nursing Care | 160,937 | 0 | | 0 | | 0 0 | 160,937 | 6. |
| | hysical Therapy | 96,470 | 0 | | 0 | | 0 0 | 96,470 | 7. |
| | ccupational Therapy peech Pathology | 44,656 | | | 0 | | 0 0 | 44,656 | |
| | edical Social Services | 4,020 3,073 | 0 | | 0 | | 0 0 | 4,020 | |
| | ome Health Aide | 56,288 | 0 | | 0 | | 0 0 | 3,073 | |
| | upplies (see instructions) | 0,200 | 0 | | 0 | | 0 0 | 56,288 | 1 |
| .00 Di | rugs | ŏ | 0 | | 0 | | 0 | 0 | |
| .00 DA | The state of the s | 0 | 0 | | Ö | | 0 0 | Ö | |
| HH | A NONREIMBURSABLE SERVICES | | | | | | | · | - : |
| | ome Dialysis Aide Services | 0 | 0 | | 0 | | 0 0 | 0 | 15. |
| | espiratory Therapy rivate Duty Nursing | 0 | 0 | | 0 | | 0 0 | 0 | 16. |
| .00 PI | | . 0 | 0 | | 0 | | 0 0 | 0 | 1 |
| | ealth Promotion Activities | 0 | 0 | | 0 | | 0 0 | 0 | 1 |
| | ay Care Program | 0 | 0 | | 0 | | 0 0 | 0 | i |
| | ome Delivered Meals Program | o | 0 | | o | | 0 0 | 0 | } |
| .00 Ho | omemaker Service | 0 | 0 | | Ō | | 0 0 | 0 | i |
| | ll Others (specify) | 71,281 | 0 | | 0 | | 0 0 | 71,281 | |
| .00 To | otal (sum of lines 1-23) | 778,278 | 0 | | 0 | | 0 | 778,278 | 24. |
| | | Administrative & General 5.00 | 4A + 5) | | | | | | |
| GE | NERAL SERVICE COST CENTERS | 3.00 | 6.00 | | *** | | | | |
| 00 Ca | apital Related - Bldg. & ixtures | | | | | | | | 1. |
| | apital Related - Movable | | | | | | | | 2. |
| | quipment | | | | | | | | - ' |
| | lant Operation & Maintenance ransportation | | | | | | | | 3. |
| 00 - Ad | dministrative and General A REIMBURSABLE SERVICES | 341,553 | | | | | | | 4. 5. |
| 0 Sk | A REIMBURSABLE SERVICES | 125,866 | 206 807 | | | | | | |
| | lysical Therapy | 75,447 | 286,803 171,917 | | | | | | 6. |
| | cupational Therapy | 34,924 | 79.580 | | | | | | 7. |
| 10 Sp | peech Pathology | 3,144 | 7,164 | | | | | | 8. 9. |
| | edical Social Services | 2,403 | 5,476 | | | | | | 10. |
| | ome Health Aide | 44,022 | 100,310 | | | | | | 11. |
| | upplies (see instructions) | 0 | 0 | | | | | | 12. |
| 00 DM | | 0 | 0 | | | | | - | 13. |
| | A NONREIMBURSABLE SERVICES | 0 | 0 | | | | | | 14. |
| 00 Ho | me Dialysis Aide Services | 0 | 0 | | | | | | 15 |
| 00 Re | spiratory Therapy | 0 | 0 | | | | | 1 | 15. |
| 00 Pr | ivate Duty Nursing | o | o | | | | | 3 | 16. 17. |
| 00 c1 | | 0 | 0 | | | | | | 18. |
| 00 He | ealth Promotion Activities | 0 | 0 | | | | | | 19. |
| OO HO | y Care Program | 0 | 0 | | | | | | 20. |
| 00 HO | me Delivered Meals Program memaker Service | 0 | 0 | | | | | | 21. |
| | 1 Others (specify) | 0 55,747 | 127 028 | | | | | | 22. |
| | tal (sum of lines 1-23) | 23,747 | 127,028 778,278 | | | | | | 23.0 |

HHA CCN:

PITAL In Lieu of Form CMS-2552-10

Provider CCN: 151322 | Period: | Worksheet H-1 | Part II | Date/Time | Prepared: | 5/30/2013 | 9:13 am

| | | | | | | | 5/30/2013 9:1 | .3 am |
|-------------|--|--|---|--|-----------------------------|------------------------|--|-------|
| | | | | | | Home Health | PPS | |
| # 11-24 No. | And the second s | Capital Re | lated Costs | | | Agency I | l | 1 |
| | | oupreur ne | .ucca coscs | | | | | |
| | | Bldgs & Fixtures (SQUARE FEET) | Movable Equipment (DOLLAR VALUE) | Plant Operation & Maintenance (SQUARE FEET) | Transportation (MILEAGE) | Reconciliation | Administrative & General (ACCUM. COST) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5A.00 | 5.00 | |
| | GENERAL SERVICE COST CENTERS | The state of the s | # Philosophic come i management in contra a management and contra | terromental and the engineering again | | december of the second | har a service a service service of the service of t | |
| 1.00 | Capital Related - Bldg. & Fixtures | 0 | | | | 0 | | 1.00 |
| 2.00 | Capital Related - Movable Equipment | | 0 | | | 0 | | 2.00 |
| 3.00 | Plant Operation & Maintenance | . 0 | 0 | a |) | 0 | | 3.00 |
| 4.00 | Transportation (see instructions) | 0 | 0 | 0 | 0 | | | 4.00 |
| 5.00 | Administrative and General HHA REIMBURSABLE SERVICES | 0 | 0 | | 0 | -341,553 | 436,725 | 5.00 |
| 6.00 | Skilled Nursing Care | 0 | 0 | 0 | 0 | 0 | 160,937 | 6.00 |
| 7.00 | Physical Therapy | 0 | 0 | Ö | Ŏ | ŏ | 96,470 | |
| 8.00 | Occupational Therapy | 0 | 0 | 0 | Ö | ŏ | 44,656 | 1 |
| 9.00 | Speech Pathology | 0 | 0 | Ö | Ó | O | 4,020 | |
| 10.00 | Medical Social Services | 0 | 0 | Ö | 0 | 0 | 3,073 | |
| 11.00 | Home Health Aide | 0 | 0 | 0 | 0 | 0 | 56,288 | |
| 12.00 | Supplies (see instructions) | 0 | 0 | 0 | 0 | 0 | 0 | |
| 13.00 | Drugs | 0 | . 0 | 0 | | 0 | Ö | |
| 14.00 | | 0 | 0 | 0 | 0 | 0 | Ö | |
| | HHA NONREIMBURSABLE SERVICES | | | | ****** | *** * | | |
| | Home Dialysis Aide Services | 0 | 0 | 0 | 0 | 0 | 0 | 15.00 |
| | Respiratory Therapy | 0 | 0 | 0 | 0 | 0 | 0 | ! |
| | Private Duty Nursing | 0 | 0 | 0 | 0 | 0 | 0 | 17.00 |
| | Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 18.00 |
| | Health Promotion Activities | 0 | 0 | 0 | 0 | 0 | 0 | 19.00 |
| | Day Care Program | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | Home Delivered Meals Program | 0 | 0 | 0 | 0 | 0 | 0 | 21.00 |
| 22.00 | Homemaker Service | 0 | 0 | 0 | 0 | 0 | 0 | 22.00 |
| 23.00 | All Others (specify) | 0 | 0 | 0 | 0 | 0 | 71,281 | |
| 24.00 | Total (sum of lines 1-23) | 0 | 0 | 0 | 0 | -341,553 | 436,725 | 24.00 |
| | Cost To Be Allocated (per Worksheet H-1, Part I) | 0 | 0 | 0 | 0 | | 341,553 | |
| 26.00 | Unit Cost Multiplier | 0.000000 | 0.000000 | 0.000000 | 0.000000 | | 0.782078 | 26.00 |

6 decimal places.

⁽¹⁾ Column 0, line 20 must agree with wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of wkst. B, Part I, line 101.

column 26, line 1, rounded to

6 decimal places.

⁽¹⁾ Column 0, line 20 must agree with wkst. A, column 7, line 101. (2) Columns 0 through 26, line 20 must agree with the corresponding columns of wkst. B, Part I, line 101.

| | | | | | | Agency I | PPS | |
|--------------|--|------------------------------------|--|---|----------------|---|---|-------|
| | the second secon | CAPITAL RE | LATED COSTS | | F | Agency 1 | | |
| | Cost Center Description | NEW BLDG & FIXT (SQUARE FEET) 1.00 | NEW MVBLE EQUIP (SQUARE FEET) 2.00 | EMPLOYEE BENEFITS (GROSS SALARIES) 4.00 | Reconciliation | ADMINISTRATIVE & GENERAL (ACCUM. COST) 5.00 | OPERATION OF PLANT (SQUARE FEET) 7.00 | |
| 1.00 | Administrative and General | 588 | | 293,494 | | The second of the second of the | | 1.00 |
| 2.00 | Skilled Nursing Care | 0 | | 202, | ŏ | | | |
| 3.00 | Physical Therapy | 0 | 1 -1 | Ö | | | | 1 |
| 4.00 | Occupational Therapy | 0 | 3 -1 | . 0 | | | | 1 |
| 5.00 | Speech Pathology | 0 | 1 -1 | . 0 | 1 | , | | |
| 6.00 | Medical Social Services | 0 | 0 | Ō | 1 | . , | | |
| 7.00 | Home Health Aide | 0 | 0 | 0 | Ŏ | | | |
| 8.00 | Supplies (see instructions) | : 0 | 0 | 0 | | , | | |
| 9.00 | Drugs | 0 | 0 | Ö | | | • | 1 |
| 10.00 | | 0 | 0 | 0 | 0 | 0 | Ö | 1 |
| | | 0 | 0 | 0 | 0 | 0 | Ö | i |
| | Respiratory Therapy | 0 | 0 | 0 | 0 | 0 | O | |
| 13.00 | | 0 | 0 | 0 | 0 | 0 | 0 | 13.00 |
| | Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 14.00 |
| | Health Promotion Activities | 0 | 0 | 0 | 0 | 0 | 0 | 15.00 |
| 16.00 | , <u></u> | 0 | 0 | 0 | 0 | 0 | 0 | 16.00 |
| | Home Delivered Meals Program | 0 | 0 | 0 | 0 | 0 | 0 | 17.00 |
| | Homemaker Service | 0 | 0 | 0 | 0 | 0 | 0 | 18.00 |
| | All Others (specify) | 0 | 0 | 0 | 0 | 127,028 | 0 | 19.00 |
| | Total (sum of lines 1-19) | 588 | | 293,494 | | 788,015 | 588 | 20.00 |
| | Total cost to be allocated | 7,927 | 621 | 1,189 | | 193,841 | 17,177 | 21.00 |
| 22.00 | Unit cost multiplier Cost Center Description | 13.481293 | 1.056122 | 0.004051 | 4 | 0.245986 | 29.212585 | 22.00 |
| | cost center bescription | LAUNDRY & LINEN SERVICE | HOUSEKEEPING (SQUARE | DIETARY (MEALS | CAFETERIA | NURSING | MEDICAL | |
| | | (POUNDS OF | FEET) | SERVED) | (FTE'S) | ADMINISTRATION | RECORDS & | |
| | | LAUNDRY) | ,, | JERVEDI | | (DIRECT | LIBRARY (TIME | |
| | | | | | | NRSING HRS) | SPENT) | |
| 2.22 | and the second s | 8.00 | 9.00 | 10.00 | 11.00 | 13.00 | 16.00 | |
| 1.00 | Administrative and General | 0 | 588 | 0 | 0 | 0 | 0 | 1.00 |
| 2.00 | Skilled Nursing Care | 0 | 0 | 0 | 0 | 0 | Ō | |
| 3.00 | Physical Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 3.00 |
| 4.00 | Occupational Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 4.00 |
| 5.00 6.00 | Speech Pathology | 0 | 0 | 0 | 1 | 0 | 0 | 5.00 |
| 7.00 | Medical Social Services Home Health Aide | 0 | 0 | 0 | - | 0 | 0 | 6.00 |
| 8.00 | | 0 | 0 | 0 | 0 | 0 | . 0 | 7.00 |
| 9.00 | Supplies (see instructions) Drugs | 0 | 0 | 0 | • | . 0 | 0 | |
| 10.00 | | 0 | 0 | 0 | | 0 | 0 | |
| 11.00 | Home Dialysis Aide Services | 0 | 0 | 0 | • | 0 | 0 | |
| 12.00 | Respiratory Therapy | 0 | 0 | 0 | • | 0 | 0 | |
| 13.00 | | 0 | 0 | 0 | 0 | 0 | 0 | |
| 14.00 | Clinic | Ô | 0 | 0 | 0 | 0 | 0 | |
| 15.00 | Health Promotion Activities | õ | o | 0 | 0 | 0 | 0 | |
| 16.00 | Day Care Program | 0 | Ŏ | n | 0 | 0 | 0 | |
| 17.00 | Home Delivered Meals Program | o | o | ő | 0 | 0 | 0 | |
| | Homemaker Service | . 0 | 0 | 0 | Ö | 0 | 0 | |
| | All Others (specify) | 0 | 0 | 0 | 0 | 0 | ő | |
| | Total (sum of lines 1-19) | 0 | 588 | 0 | 0 | 0 | Ö | |
| | Total cost to be allocated | 0 | 5,026 | 0 | 0 | 0 | 0 | 21.00 |
| 22.00 | Unit cost multiplier | 0.000000 | 8.547619 | 0.000000 | 0.000000 | 0.000000 | 0.000000 | 22.00 |

| APPORT: | Financial Systems | | | Provider | CCN: 151322 | eriod: | Worksheet H-3 | |
|--|---|--|--|---|--|---|---|--|
| | IONMENT OF PATIENT SERVICE COST | S | | HHA CCN: | | From 01/01/2012 To 12/31/2012 | Part I Date/Time Prepa 5/30/2013 9:13 | red am |
| | | | | Titl | e XVIII | Home Health Agency I | PPS | |
| | Cost Center Description | | Facility Costs (from Wkst. | Shared Ancillary | Total HHA Costs (cols. | Total Visits | Per Visit | |
| | | H-2, Part I, col. 28, line | | Costs (from Part II) | + 2) | | (col. 3 ÷ col. 4) | |
| | | | 1.00 | 2 00 | 3.00 | 4.00 | 5.00 | |
| | PART I - COMPUTATION OF LESSER | OF AGGREGATE P | ROGRAM COST, A | GREGATE OF TH | HE PROGRAM LIM | ITATION COST, OF | , | |
| | BENEFICIARY COST LIMITATION | O, ACCRECATION . | | The second of the second of the second | and the state of t | war was a sure of the second second second | and the control of the control of the | |
| | Cost Per Visit Computation | The second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second | | | 1 270.00 | 2,372 | 155.99 | 1. |
| 1.00 | Skilled Nursing Care | 2.00 | | | 370,00 0 221,79 | - 100 | | 2. |
| 2.00 | Physical Therapy | 3.00 | | | | | | 3. |
| 3.00 | Occupational Therapy | 4.00 | | | | | | 4 |
| 4.00 | Speech Pathology | 5.00 | | | 0 9,24 | | ` | 5 |
| 5.00 | Medical Social Services | 6.00 | 7,065 | | 7,00 | | 1 | 6 |
| | Home Health Aide | 7.00 | 129,410 | | 129,4 | | | 7. |
| 6.00 | Total (sum of lines 1-6) | | 840,180 | | 0 840,1 | | | |
| 7.00 | Total (sum of times = 5) | | | | Program Visi | | | |
| | | | | | | art B | | |
| | Cost Center Description | Cost Limits | CBSA No. (1) | Part A | Not Subject Deductibles | & Deductibles | | |
| | | i | | | Coinsurance | | r 00 | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | Limitation Cost Computation | | | | 4.1 | | 1 | 8 |
| | chilled Numering Care | | 15999 | | | 48 | | 9 |
| | Skilled Nursing Care | | 15999 | 77 | | 86 | | 10 |
| 11.00 | Physical Therapy | | 15999 | 3! | | 23 | | 11 |
| | Occupational Therapy | | 15999 | | • | 39 | | 12 |
| | Speech Pathology | | 15999 | | - | 15 | 1 | 13 |
| 12.00 | Medical Social Services | | 15999 | 1 | | .82 | | 14 |
| 13.00 | Home Health Aide | | | 2,0 | | | (-n1 2 | 1 1~ |
| 14.00 | Total (sum of lines 8-13) Cost Center Description | From Wkst. H- | 2 Facility Costs | Shared | Total HHA | | s Ratio (col. 3 ÷ col. 4) | 1 |
| | Cost Center Description | Part I, col. | (from Wkst. | Anchiary | Costs (cols | 1 (from HHA | ÷ (01. 4) | |
| | | 28, line | H-2, Part 1) | Costs (from | n + 2) | Record) | | 1 |
| | | , | | Part II) | | 4 00 | 5.00 | ļ |
| | | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 3.00 | |
| | Supplies and Drugs Cost Compu | tations | | | <u>1</u> | 0 87,12 | 0.000000 | 19 |
| 15 M | Cost of Medical Supplies | 8.0 | | 0 | 0 | | | |
| 16.00 | Cost of Drugs | 9.0 | 0 | 0 1 | | 182 75 | 0.232.00 | 1 |
| 10.00 | , cose o, b. 293 | | Program Visit | S | Cost of | | | |
| | | | | | Services | Part B | | į. |
| | | | | rt B | | Not Subject 1 | to Subject to | |
| | Cost Center Description | Part A | Not Subject t | o Subject to | Part A | Daductibles | & Deductibles & | İ |
| | cost contain product | | | Deductibles | & | Coinsurance | | |
| | | | Coinsurance | Coinsuranc | | 10.00 | 11.00 | |
| | | | 7.00 | 8.00 | 9.00 | | | |
| | | 6.00 | | | THE DROCDAM I | | * * | 1 |
| | PART I - COMPUTATION OF LESSE | R OF AGGREGATE | PROGRAM COST, | AGGREGATE OF | THE PROGRAM L | IMITATION COST, | | į |
| | PART I - COMPUTATION OF LESSE BENEFICIARY COST LIMITATION | R OF AGGREGATE | PROGRAM COST, | AGGREGATE OF | THE PROGRAM L | IMITATION COST, | | 1 |
| | Cost Per Visit Computation | R OF AGGREGATE | | AGGREGATE OF | | | | |
| 1.00 | Cost Per Visit Computation | R OF AGGREGATE | 21 54 | AGGREGATE OF | 112, | 469 85,4 | 83 | 4 |
| 1.00 2.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy | er of aggregate 7 7 | 21 54 22 38 | AGGREGATE OF | 112, 113, | 469 85,4 896 60,8 | 83 92 | 4 |
| 2.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy | er of aggregate 7 7 | 21 54 22 38 58 22 | AGGREGATE OF | 112, 113, | 469 85,4 896 60,8 797 29,7 | 83 92 73 | 4 |
| 2.00 3.00 | BENEFICIARY COST LIMITATION Cost Per visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology | er of aggregate 7 7 | 21 54 22 38 58 22 | AGGREGATE OF | 112, 113, 47, | 469 85,4 896 60,8 797 29,7 188 5,1 | 83 92 73 49 | Marroment |
| 2.00 3.00 4.00 | BENEFICIARY COST LIMITATION Cost Per visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology | 7. 7. 7. 3 | 21 54 22 38 58 22 9 8 | AGGREGATE OF | 112, 113, 47, 1, | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 | 83 92 73 49 25 | Andrew Control (Special |
| 2.00 3.00 4.00 5.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide | 7 AGGREGATE 7 3 | 21 54 22 38 58 22 9 8 | AGGREGATE OF 8 66 63 99 55 | 112, 113, 47, 1, 2, | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 076 18,0 | 83 92 73 49 25 176 | Andrews Andrews |
| 2.00 3.00 4.00 5.00 6.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide | 7. 7. 7. 3 | 21 54 22 38 58 22 9 8 | AGGREGATE OF 8 66 63 99 55 | 112, 113, 47, 1, 2, | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 | 83 92 73 49 25 176 | The state of the s |
| 2.00 3.00 4.00 5.00 | BENEFICIARY COST LIMITATION Cost Per visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide | 7 7 7 3 1 2.0 | 21 54 22 38 58 22 9 8 8 18 82 14 00 1,39 | AGGREGATE OF 8 6 6 13 19 15 15 16 17 18 18 18 18 18 18 18 18 18 | 112, 113, 47, 1, 2, | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 076 18,0 | 83 92 73 49 25 176 | Andrews Andrews |
| 2.00 3.00 4.00 5.00 6.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description | 7 7 7 3 1 2 ,0 | 21 54 22 38 58 22 9 8 | AGGREGATE OF 8 66 63 99 55 | 112, 113, 47, 1, 2, 18, 295 | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 076 18,0 519 203,2 | 83 92 73 49 25 76 | Andrews Andrews |
| 2.00 3.00 4.00 5.00 6.00 7.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description | 7 7 7 3 1 2.0 | 21 54 22 38 58 22 9 8 8 18 82 14 00 1,39 | AGGREGATE OF 8 6 6 13 19 15 15 16 17 18 18 18 18 18 18 18 18 18 | 112, 113, 47, 1, 2, 18, 295 | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 076 18,0 519 203,2 | 83 92 73 49 25 76 | Andrews Andrews |
| 2.00 3.00 4.00 5.00 6.00 7.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care | 7 7 7 3 1 2.0 | 21 54 22 38 58 22 9 8 8 18 82 14 00 1,39 | AGGREGATE OF 8 6 6 13 19 15 15 16 17 18 18 18 18 18 18 18 18 18 | 112, 113, 47, 1, 2, 18, 295 | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 076 18,0 519 203,2 | 83 92 73 49 25 76 | eginner autoriteraturati stressi i materiale i decenti del constitución de la constitució |
| 2.00 3.00 4.00 5.00 6.00 7.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy | 7 7 7 3 1 2.0 | 21 54 22 38 58 22 9 8 8 18 82 14 00 1,39 | AGGREGATE OF 8 6 6 13 19 15 15 16 17 18 18 18 18 18 18 18 18 18 | 112, 113, 47, 1, 2, 18, 295 | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 076 18,0 519 203,2 | 83 92 73 49 25 76 | Accompany town - when a death of the contraction of |
| 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy | 7 7 7 3 1 2.0 | 21 54 22 38 58 22 9 8 8 18 82 14 00 1,39 | AGGREGATE OF 8 6 6 13 19 15 15 16 17 18 18 18 18 18 18 18 18 18 | 112, 113, 47, 1, 2, 18, 295 | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 076 18,0 519 203,2 | 83 92 73 49 25 76 | The first territory of the first territory of |
| 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy | 7 7 7 3 1 2.0 | 21 54 22 38 58 22 9 8 8 18 82 14 00 1,39 | AGGREGATE OF 8 6 6 13 19 15 15 16 17 18 18 18 18 18 18 18 18 18 | 112, 113, 47, 1, 2, 18, 295 | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 076 18,0 519 203,2 | 83 92 73 49 25 76 | The state of the s |
| 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.0 | BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy | 7 7 7 3 1 2.0 | 21 54 22 38 58 22 9 8 8 18 82 14 00 1,39 | AGGREGATE OF 8 6 6 13 19 15 15 16 17 18 18 18 18 18 18 18 18 18 | 112, 113, 47, 1, 2, 18, 295 | 469 85,4 896 60,8 797 29,7 188 5,1 093 3,9 076 18,0 519 203,2 | 83 92 73 49 25 76 | |

| Health Financial Systems | | PERRY COUNTY | / HOSPITAL | | In Lie | u of Form CMS-2552-1 |
|--|--|-------------------------|--|---|---|----------------------|
| APPORTIONMENT OF PATIENT SERVICE COST | | HHA CCN: | | Period: From 01/01/2012 | Worksheet H-3 Part II | |
| | | | | e XVIII | Home Health Agency I | PPS |
| Cost Center Description | From Wkst. C, Part I, col. 9, line | Cost to Charge Ratio | Total HHA Charge (from provider records) | HHA Shared Ancillary Costs (col. x col. 2) | Transfer to Part I as | |
| The second secon | 0 | 1.00 | 2.00 | 3.00 | 4.00 | |
| PART II - APPORTIONMENT OF COS | T OF HHA SERVI | CES FURNISHED B | Y SHARED HOSPI | TAL DEPARTMEN | VTS | ******* |
| 1.00 Physical Therapy 2.00 Occupational Therapy 3.00 Speech Pathology | 66.00 67.00 68.00 | 0.417024 0.270796 | 0 | | Ocol. 2, line 2 Ocol. 2, line 3 | .00 2.0 |
| 4.00 Cost of Medical Supplies 5.00 Cost of Drugs | 71.00 73.00 | 0.111142 | _ | 1 | 0 col. 2, line 4 0 col. 2, line 1! 82 col. 2, line 10 | 5.00 4.0 |

| | JLATION OF HHA REIMBURSEMENT SETTLEMENT | | | Provider HHA CCN: | CCN: 151322 157177 | Period: From 01/01, To 12/31, | | Date/Time Pre | pared |
|--|--|----------------|---------|----------------------|---|--|--|--|--|
| | | | | Titl | le XVIII | Home Hea Agency | | 5/30/2013 9:1 PPS | .3 am |
| | | | | | Part A | Part (Not Subject Deductibl Coinsura | t to | Deductibles & Coinsurance | |
| | PART I - COMPUTATION OF THE LESSER OF REAS | ONABLE COST OR | CUSTOMA | RY CHARGE | 1.00 S | 2.00 | | 3.00 | |
| 1.00 | Reasonable Cost of Part A & Part B Service Reasonable cost of services | S | | | 4 | nut | | | İ |
| 1.00 | (see instructions) | | | | | 0 , | 176 | 0 | 1.0 |
| 2.00 | in the same of the | | | | | 0 | 759 | 0 | 2.0 |
| 3.00 | Customary Charges Amount actually collected from | | | | | 0 | 0 | | |
| | patients liable for payment | | | | | U ₁ | U | 0 | 3.0 |
| | for services on a charge basis (from your records) | | | | | | | | |
| .00 | Amount that would have been | | | | | 0 | 0 | 0 | 4.0 |
| | realized from patients liable | | | | | | Ū | V | 7.0 |
| | for payment for services on a charge basis had such payment | | | | | | | | |
| | been made in accordance with | | | | | | | | |
| .00 | 42 CFR 413.13(b) Ratio of line 3 to line 4 (not | | | | 0.0000 | 20 | 0000 | | l |
| | to exceed 1.000000) | | | | 0.00000 | 0.00 | 10000 | 0.00000 | 5.0 |
| .00 | Total customary charges (see instructions) | | | | | 0 | 759 | 0 | 6.0 |
| .00 | Excess of total customary | | | | | n | 583 | 0 | 7.0 |
| | charges over total reasonable | | | | *************************************** | | 505 | U | /.0 |
| | cost (complete only if line 6 exceeds line 1) | | | | | | | | |
| 00 | Excess of reasonable cost over | | | | | 0 | 0 | 0 | 8.0 |
| | customary charges (complete only if line 1 exceeds line 6) | | | | | i | | | - |
| .00 | Primary payer amounts | | | | | i | | | 0.0 |
| | | | | | | 0 | 0 | 0 | |
| | | | * ** | | | Part A Service | | Part B Services | 9.0 |
| | PART II - COMPUTATION OF HHA REIMBURSEMENT | SETTLEMENT | | | | Part A | | Part B | 9.0 |
| 00.00 | PART II - COMPUTATION OF HHA REIMBURSEMENT Total reasonable cost (see instructions) | SETTLEMENT | | | | Part A Service | | Part B Services 2.00 | |
| | Total reasonable cost (see instructions) Total PPS Reimbursement - Full | SETTLEMENT | | | | Part A Service 1.00 | s 0 | Part B Services 2.00 | 10.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers | SETTLEMENT | | | | Part A Service 1.00 | s 0 ,057 | Part B Services 2.00 176 198,431 | 10.0 |
| L.00 2.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers | SETTLEMENT | | | | Part A Service 1.00 | s 0 | Part B Services 2.00 176 198,431 | 10.0 |
| 00 00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA | SETTLEMENT | | | | Part A Service 1.00 | s 0 ,057 | Part B Services 2.00 176 198,431 | 10.0 11.0 12.0 |
| L.00 2.00 3.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 | Part B Services 2.00 176 198,431 0 4,199 | 10.0 11.0 12.0 |
| 2.00 2.00 3.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes | SETTLEMENT | | | | Part A Service 1.00 | s 0 ,057 | Part B Services 2.00 176 198,431 0 4,199 | 10.0 11.0 12.0 13.0 |
| 1.00 2.00 3.00 4.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Total PPS Reimbursement - PEP Total PPS Reimbursement - PEP Total PPS Outlier | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 | Part B Services 2.00 176 198,431 0 4,199 | 10.0 11.0 12.0 13.0 |
| 2.00 2.00 3.00 3.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 | Part B Services 2.00 176 198,431 0 4,199 | 10.0 11.0 12.0 13.0 |
| 2.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 | Part B Services 2.00 176 198,431 0 4,199 | 10.0 11.0 12.0 13.0 14.0 |
| 2.00 2.00 3.00 3.00 5.00 5.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 | Part B Services 2.00 176 198,431 0 4,199 0 | 10.0 11.0 12.0 13.0 14.0 15.0 |
| 2.00 2.00 3.00 3.00 3.00 3.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments | SETTLEMENT | | | | Part A Service 1.00 | o ,057 0 ,030 733 | Part B Services 2.00 176 198,431 0 4,199 | 10.0 11.0 12.0 13.0 14.0 15.0 |
| 00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 | 10.cc 11.cc 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0 |
| 2.00 2.00 3.00 3.00 3.00 3.00 3.00 3.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments | SETTLEMENT | | | | Part A Service 1.00 | 0,057 0,030 733 0 | Part B Services 2.00 176 198,431 0 4,199 0 | 10.cc 11.cc 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0 |
| .00.00.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 | 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0 20.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments OXYGEN PAYMENTS Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 0 | 10.0 11.0 13.0 14.0 15.0 16.0 17.0 19.0 20.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 | 10.0 11.0 13.0 14.0 15.0 16.0 17.0 19.0 20.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 0 0 | 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 19.0 20.0 21.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 0 0 0 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 0 0 0 0 | 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 19.0 20.0 21.0 22.0 23.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 0 0 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 0 0 | 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 19.0 20.0 21.0 22.0 23.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments PME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 0 0 0 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 0 202,806 0 202,806 | 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 20.0 21.0 22.0 24.0 24.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments PME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line | SETTLEMENT | | | | Part A Service 1.00 | s 0 0 ,057 0 0 ,030 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 0 0 0 0 0 202,806 | 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0 20.0 21.0 22.0 23.0 24.0 25.0 25.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 0 0 0 0 0 0 ,820 | Part B Services 2.00 176 198,431 0 4,199 0 0 0 202,806 0 202,806 0 202,806 | 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 19.0 20.0 21.0 22.0 24.0 24.0 25.0 26.0 26.0 26.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) | SETTLEMENT | | | | Part A Service 1.00 | s 0 0 ,057 0 0 ,030 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | Part B Services 2.00 176 198,431 0 4,199 0 0 0 202,806 0 202,806 0 202,806 | 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 19.0 20.0 21.0 22.0 23.0 24.0 25.0 25.0 |
| 2.00 2.00 3.00 3.00 3.00 3.00 3.00 3.00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from | SETTLEMENT | | | | Part A Service 1.00 | 0 ,057 0 ,030 733 0 0 0 0 0 0 0 ,820 | Part B Services 2.00 176 198,431 0 4,199 0 0 0 202,806 0 202,806 0 202,806 | 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 20.0 21.0 22.0 24.0 25.0 26.0 26.0 26.0 |

| Health Financial Systems | ERRY COUNTY HOSPITAL | In Lie | u of Form CMS- | 2552-10 |
|---|---|---|--|---------|
| CALCULATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CCN: 151322 HHA CCN: 157177 | Period: From 01/01/2012 To 12/31/2012 | | pared: |
| e e e e e e e e e e e e e e e e e e e | Title XVIII | Home Health Agency I | PPS | |
| | | Part A Services 1.00 | Part B Services 2.00 | |
| 29.00 Total costs - current cost reporting period (line 26 plus line 27) | | 301,820 | The state of the second company of the second secon | 29.00 |
| 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | 0 | 0 | 30.00 |
| 31.00 Subtotal (line 29 plus/minus line 30) | | 301,820 | 202,806 | 31.00 |
| 32.00 Interim payments (see instructions) | | 301,820 | 203,362 | 32.00 |
| 33.00 Tentative settlement (for contractor use only) | | 0 | 0 | 33.00 |
| 34.00 Balance due provider/program (line 31 minus lines 32 and 33) | | o | -556 | 34.00 |
| 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2 | | 0 | 0 | 35.00 |

| ANALYS | SIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED | TO Provider | CCN: 151322 | Period: | Worksheet H-5 | |
|------------|--|-------------|-------------|----------------------------------|---------------------------------|------------|
| - KUGR/ | AM BENEFICIARIES | HHA CCN: | 157177 | From 01/01/2012 To 12/31/2012 | Date/Time Prep 5/30/2013 9:1 | |
| | | | | Home Health | PPS | |
| - | en en en en en en en en en en en en en e | Inpatient | Part A | Agency I Part B | | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | The state of the s | 1.00 | 2.00 | 3.00 | 4.00 | ~~ |
| .00 | Total interim payments paid to provider | | 301,8 | 20 | 203,362 | 1.0 |
| .00 | Interim payments payable on | | | 0 | 0 | |
| | individual bills, either | | | V . | 0 | 2.0 |
| | submitted or to be submitted | | | | | |
| | to the contractor for services rendered in the cost reporting | | | | | |
| | period. If none, write "NONE" | | | | | |
| 00 | or enter a zero | | | | | |
| 00 | List separately each retroactive lump sum | | | | | 3.0 |
| | adjustment amount based on | | | | | |
| | subsequent revision of the | | | | | |
| | interim rate for the cost reporting period. Also show | | | | | |
| | date of each payment. If none, | | | | | |
| | write "NONE" or enter a zero. | | | | | |
| | (1) Program to Provider | | | | | |
| 01 | rrogram to rroyide) | 1 | | 0 | 0 | 9. |
| 02 | | | | 0 | 0 | |
|)3)4 | | | | 0 | Ō | |
| 5 | | | | 0 | 0 | ٠. |
| | Provider to Program | 1 | | 0 | 0 | 3. |
| 0 | | | | 0 | Ö | 3. |
| 1 2 | | | | 0 | 0 | 3. |
| 3 | | | | 0 | 0 | 3. |
| 4 | | | | 0 | 0 | 3.: 3.: |
| 99 | Subtotal (sum of lines | | | Ŏ | 0 | 3.9 |
| | 3.01-3.49 minus sum of lines 3.50-3.98) | | | | | |
| 0 | Total interim payments (sum of | | 301,82 | 0 | 202 762 | |
| | lines 1, 2, and 3.99) | | 301,62 | .0 | 203,362 | 4.6 |
| | (transfer to Wkst. H-4, Part | | | | | |
| | II, column as appropriate, line 32) | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | 1 | | | | |
| 0 | List separately each tentative | | | : | | 5.4 |
| | settlement payment after desk review. Also show date of each | | | | - | |
| | payment. If none, write "NONE" | | | | | |
| | or enter a zero. (1) | | | | | |
| 1 | Program to Provider | | | _1 | | |
| 2 | | | | 0 | 0 | 5.0 |
| 3 | | | | 0 | 0 | 5.0 |
| ^ | Provider to Program | • | | | | ٠.٠ |
| 0 | | | | 0 | 0 | 5.5 |
| 2 | | | | 0 | 0 | 5.5 |
| 9 | Subtotal (sum of lines | | | 0 | 0 | 5.5 5.9 |
| | 5.01-5.49 minus sum of lines | | | -; | U | ٠.5 |
| | 5.50-5.98) Determined net settlement | | | | | |
| | amount (balance due) based on | | | | | 6.0 |
| | the cost report. (1) | | | | | |
| | SETTLEMENT TO PROVIDER | | | 0 | o | 6.0 |
| 12 10 : | SETTLEMENT TO PROGRAM Total Medicare program | | | 0 | 556 | 6.0 |
| | IVEG MEG (LATE HITHHIAM) | | 301,82 | A: | 202,806 | 7.00 |

| Health Financial Systems | | In Lie | In Lieu of Form CMS-2552-1 | | | | |
|--|---|----------------|----------------------------|----------|----------------------------|--------------------------------|------|
| ANALYSIS OF PAYMENTS TO PRO PROGRAM BENEFICIARIES | VIDER-BASED HHAS FOR SERVIC | ES RENDERED TO | Provider CCN | : 151322 | Period: From 01/01/2012 | Worksheet H-5 | |
| | Marie Carlos Control of the Control | AMERICA | HHA CCN: | 157177 | To 12/31/2012 | Date/Time Pre 5/30/2013 9:1 | |
| the second of the second of the second of | | | 221.72 | | Home Health Agency I | PPS | |
| | | | | | Contractor Number | Date (Mo/Dav/Yr) | |
| 8.00 Name of Contractor | | | <u> </u> | | 1.00 | 2.00 | |
| or contractor | 1 | ĺ | | | | | 8.00 |